



NEW JERSEY

# Child Fatality & Near Fatality

REVIEW BOARD

2009 ANNUAL REPORT

ISSUED  
DECEMBER  
2010



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Audrey Hepburn Children's House

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Gloucester County Prosecutor's Office

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Robert Wood Johnson University Hospital

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Office of the Child Advocate  
Designee: Maria McGowan

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Office of the State Medical Examiner

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New Jersey State Police  
Designee: Det. Sgt. Jeffrey Kronenfeld

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NJ Task Force on Child Abuse  
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Hackensack University Medical Center

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Special Victims Unit  
Hudson County Prosecutor's Office

**CATHY FANTUZZI, Esq.**

Assistant Prosecutor  
Bergen County Prosecutor's Office  
Designee: Danielle Grootenboer

**ALBERT SANZ, M.D., F.A.A.P.**

Attending Pediatrician  
Great Falls Pediatrics  
St. Joseph's Children's Hospital

**SHARON PSOTA, MSW**

Casework Supervisor  
Western Essex Central Local Office  
Division of Youth and Family Services  
Department of Children and Families

**MARYANN CLAYTON, M.D.**

Assistant Medical Examiner  
Bergen County Medical Examiner's Office  
Hackensack University Medical Center

### VICE-CHAIR

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Director of Pediatric Emergency Room  
Hackensack University Medical Center

**LESLEY ELTON, M.D.**

Child Protection Physician  
Audrey Hepburn Children's House

**STEPHEN PERCY, JR., M.D., MBA, F.A.A.P.**

Vice Chairman, Department of Pediatrics  
Associate Director, Pediatric  
Intensive Care Unit  
Hackensack University Medical Center

**LILIANA PINETE, M.D., MPH**

Vice President, Program Development  
and Evaluation  
Northern New Jersey Maternal Child  
Health Consortium

**KIM DRAYTON**

Casework Supervisor  
Passaic Central Local Office  
Division of Youth and Family Services  
Department of Children and Families

**ARLENE COHN**

Law Guardian  
Office of the Public Defender

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### CHAIR

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Metropolitan Regional Diagnostic  
and Treatment Center

#### **RAKSHA GAJARAWALA, M.D.**

Pediatric Physician Consultant  
Division of Youth and Family Services  
Department of Children and Families

#### **THOMAS BLUMENFELD, M.D.**

Assistant Medical Examiner  
Northern Regional Medical Examiner's Office

#### **GUADALUPE CASILLAS, Esq.**

Law Guardian  
Office of the Public Defender  
Designee: Ellen Goldfinger

#### **MADLINE J. DELRIOS, MSW**

Assistant Area Director  
Middlesex Area Office  
Division of Youth and Family Services  
Department of Children and Families

#### **JOHN ESMERADO, Esq.**

Assistant Prosecutor  
Union County Prosecutor's Office  
Union County Child Advocacy Center

#### **YOLANDA STERLING, MSW**

Case Practice Specialist  
Western Essex Area Office  
Division of Youth and Family Services  
Department of Children and Families

#### **CARLY RYAN, MA**

FIMR Coordinator  
Gateway Northwest Maternal  
Child Health Network

#### **MARK ALI, Esq.**

Assistant Prosecutor  
Essex County Prosecutor's Office

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### CHAIR

#### **LINDA SHAW, M.D., MSSW**

Medical Director  
Dorothy B. Hersh Child Protection Center

#### **CARYL SCHERER, MSW, LSW**

Assistant Area Director  
Monmouth/Ocean Area Office  
Division of Youth and Family Services  
Department of Children and Families

#### **LILLIAN BRENNAN, Esq.**

Law Guardian  
Office of the Public Defender

#### **FREDERICK DICARLO, M.D.**

Assistant County Medical Examiner  
Middlesex County Medical  
Examiner's Office

#### **LT. KAREN ORTMAN**

Mercer County Prosecutor's Office

#### **PETER J. BOSER, Esq.**

Director  
Sex Crimes/Child Abuse Unit  
Monmouth County Prosecutor's Office

continued

Central Regional Community-Based Review Team Members - continued

**LINDA ESPOSITO, PH.D., MPH, BSN, RN**

Coordinator of Education, Research,  
and Communication  
SIDS Center of New Jersey  
UMDNJ-Robert Wood Johnson Medical School

**NANCY CARRÉ-LEE, MSW**

Assistant Area Director  
Burlington/Mercer Area Office  
Division of Youth and Family Services  
Department of Children and Families

**CYNTHIA W. LISCHICK, Ph.D., DVS**

Director  
PALS WomenAware

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Assistant Professor of Pediatrics  
CARES Institute  
UMDNJ-School of Osteopathic Medicine

**ALEEMA ABDUR-RAHMAN**

Camden Central Local Office  
Division of Youth and Family Services  
Department of Children and Families

**WANDA WESLEY, CSW**

Administrative Analyst  
Burlington/Mercer Area Office  
Division of Youth and Family Services  
Department of Children and Families

**JANET FAYTER, Esq.**

Law Guardian  
Office of the Public Defender

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**GREGORY SMITH, Esq.**

Camden County Prosecutor's Office

**GERALD FEIGIN, M.D.**

Gloucester County Medical  
Examiner's Office

**CAPTAIN FREDERICK D'ASCENTIS**

Burlington County Prosecutor's Office

**BARBARA MAY, RN, BSN**

Southern NJ Perinatal  
Cooperative, Inc.

**SGT. DAVID S. WEISS**

Atlantic County Prosecutor's Office

**PAMELA D'ARCY, Esq.**

Assistant Prosecutor  
Atlantic County Prosecutor's Office

# Introduction

## Child Fatality & Near Fatality Review Board's Mission

### In the United States:

- More than 4,600 infants die each year unexpectedly
- An estimated 1,760 children died as a result of being abused or neglected in 2007; almost five children per day

## Purpose, mandate, and scope of the CFNFRB

The New Jersey Child Fatality and Near Fatality Review Board herein referred to as the Board or CFNFRB was established after the adoption of the N.J.S.A. 9:6-8.88, the New Jersey Comprehensive Child Abuse Prevention and Treatment Act (CCAPTA) on July 31, 1997. Although this Board was established within the Department of Human Services (later amended to the Department of Children and Families when DCF was established on July 1, 2006), it is statutorily independent of "any supervision or control by the department or any board or officer thereof." The CFNFRB also serves as a Citizen Review Panel, mandated under the federal Child Abuse Prevention and Treatment Act (CAPTA) and its subsequent amendments to examine the policies, practices and procedures of state and local agencies and, where appropriate, specific cases to determine the extent to which the agencies are effectively discharging their child protection responsibilities.

The principal objective of the Child Fatality and Near Fatality Review Board is to provide an impartial review of individual case circumstances and to develop recommendations for broad-based systemic, policy, and legislative revisions for the purpose of preventing future tragedies. According to CCAPTA, the purpose of the Board includes but is not limited to the following:

- To review child fatalities and near fatalities in New Jersey in order to identify the cause of the incident, the relationship of the incident to governmental support systems, as determined relevant by the Board, and methods of prevention.
- To describe trends and patterns of child fatalities and near fatalities in New Jersey based upon its case reviews and findings.
- To evaluate the response of government support systems to the children and families who are reviewed and to offer recommendations for systemic improvements, especially those that are related to future prevention strategies.
- To identify groups at high risk for child abuse and neglect or child fatality, in terms that support the development of responsive public policy.
- To improve data collection sources by developing protocols for autopsies, death investigations, and the complete recording of the cause of death on the death certificate, and make recommendations for system-wide improvements in data collection for the purpose of improved evaluation, potential research, and general accuracy of the archive.

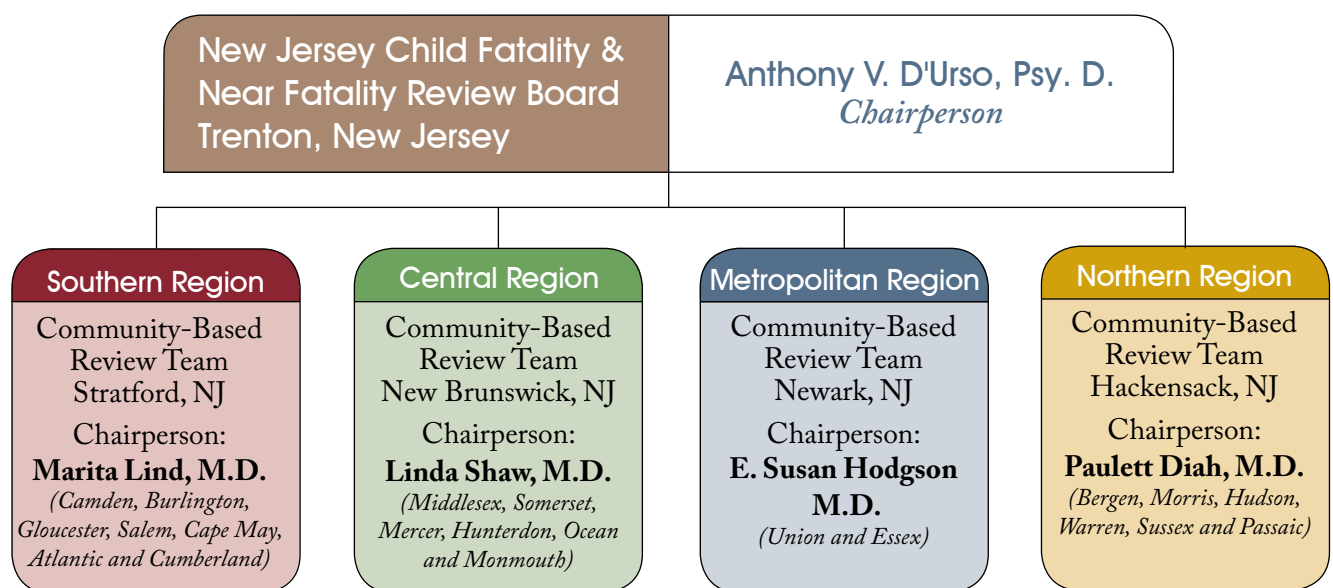


Reviewing the circumstances surrounding cases of child fatalities and near fatalities is a critically important task for state and local professionals working in an array of fields, including child welfare, law enforcement, health, judicial, medical examiner, mental health, education and substance abuse. Recognizing that deaths and near fatalities of children and youth are a sentinel event, a comprehensive review by the community allows for a better understanding and identification of potential risk factors to surviving siblings and other children. In essence, the Board functions as a catalyst for needed change.

These reviews also allow a multidisciplinary team of professionals to comprehensively examine child deaths and near fatalities. Doing so allows for a determination as to why children die so that action and follow up recommendations can be implemented to prevent future deaths, develop needed service resources and improve the safety and well being of children overall.

The CFNFRB does not review all fatalities and near fatalities, but always reviews those which come to their attention involving abuse, neglect, violence, or appear preventable. The Board's data is based on this selection.

A central and guiding principle of the CFNFRB is that reviews permit the community to learn from each child fatality and near fatality and promotes ownership of prevention initiative and strategies. Subsequently, the CFNFRB established regional community-based teams with the support and cooperation of the four New Jersey Regional Child Abuse Diagnostic and Treatment Centers. The teams' membership is multidisciplinary and has expertise in the area of pediatrics, child welfare, substance abuse, law enforcement, psychology, and public health.



The state board reviews cases which were open at the time of death or near fatality with the Division of Youth and Family Services (DYFS), New Jersey's child protection and child welfare agency. The Northern, Metropolitan, Central, and Southern Teams, review all other cases meeting review criteria described below and have no active DYFS involvement at the time of the fatal or near fatal incident.

## Case Selection Criteria

According to N.J.S.A. 9:6-8.90, the duties of the CFNFRB include review of fatalities due to unusual circumstances, using the following criteria:

- The cause of death is undetermined
- Deaths where substance abuse may have been a contributing factor
- Homicide due to child abuse or neglect
- Death where child abuse or neglect may have been a contributing factor
- Malnutrition, dehydration, or medical neglect or failure to thrive
- Sexual Abuse
- Head trauma, fractures, or blunt force trauma without obvious innocent reason, such as auto accidents
- Suffocation or asphyxia
- Burns without obvious innocent reason, such as auto accident or house fire;
- Suicide

The CCAPTA guidelines also mandate that the CFNFRB identify children whose families were under the Division of Youth and Family Services (DYFS) supervision at the time of the fatal or near fatal incident or within 12 months immediately preceding the fatal or near fatal incident.

The CFNFRB also requires the review of "near fatalities" (a serious or critical condition, as certified by a physician, in which a child suffers a permanent neurological or physical impairment, a life-threatening injury, or condition that creates a probability of death with in the foreseeable future); pursuant to N.J.S.A. 9:6-8.84.

In addition to those reviews captured by the CCAPTA guidelines, the Board also elects to review:

- All drowning fatalities
- Motor vehicle accidents in which the driver:
  - 1) Was under the age of 18 and toxicology results were positive
  - 2) Was under the supervision of DYFS
- All Sudden Unexpected Infant Deaths (SUID); which include children whose cause of death is Sudden Infant Death Syndrome (SIDS)

<b>CFNFRB findings at a glance</b>		<b>64%</b> of the infant fatalities reviewed died in unsafe sleep environments. In 2008, an average of one infant per month died as a result of accidental suffocation.
<b>89%</b> of teens who died due to substance abuse overdose or toxicity had received substance abuse treatment services.		Swimming pool deaths are highest in the 1-4 year old age group. <b>82%</b> of drowning victims were supervised by adults engaged in distracting activities.
<b>63%</b> of suicide deaths were White (non-Hispanic) children.	Two out of every three adolescent homicide victims were killed by a firearm.	
In 27% of fatalities or near fatalities, there were concerns with inaccurate Risk Assessments; including errors which may have increased risk level, thereby requiring a case stay open and closure of high/very high risk cases lacking documentation justifying closure.		<b>43 families of children who died were under DYFS supervision at the time of the fatality.</b>

## Review Process

The CFNFRB is notified of child deaths from several sources, including the State Central Registry (SCR), the Office of the State Medical Examiner, and upon request, the Department of Health and Senior Services. Near fatal incidents are identified for review through the SCR. Once a case is identified for review, liaison staff is responsible for obtaining all relevant records, including but not limited to, autopsy, death scene investigation, medical and social service records. The CFNFRB has subpoena authority to secure the required materials if necessary.

Staff liaisons forward all relevant documentation to CFNFRB members approximately two weeks before a scheduled meeting for the member's review and preparation for the discussion at the meeting.

Some of the possible actions following each case review may include policy and practice changes in particular fields, strengthened interagency collaboration, the need for staff training, public outreach and education or changes to state law. Lessons learned from these tragedies lead to stronger prevention efforts that keep children safe, healthy and protected.

In 2009, the CFNFRB reviewed a total of 184 fatality and six near fatality cases. Table 1-1 shows the demographics of cases reviewed by the CFNFRB. Although most fatalities occurred in 2008, it is important to note that not all fatalities occurred in that calendar year. 12 fatalities that occurred in 2007 were also reviewed, as were two expedited cases of deaths which occurred in 2009. These cases were deemed expedited after Board members agreed that possible systemic issues were apparent and immediate recommendations and follow up were necessary.

Table 1-1

## Cases Reviewed in 2009 by Race/Ethnicity, Gender, and Age Group

	Reviewed by CFNFRB	2008 Population under age 18 <sup>1</sup>
<b>Race/Ethnicity</b>		
White (non-Hispanic)	48	1,113,037
Black (non-Hispanic)	89	302,685
Hispanic (all races)	43	424,217
Other <sup>2</sup>	10	207,643
<b>Gender</b>		
Male	109	1,049,056
Female	81	998,526
<b>Age Group</b>		
1 year old	113	114,597
1-4 years old	30	442,824
5-9 years old	7	556,446
10-14 years old	16	572,584
15-17 years old	24	361,131
<b>TOTAL</b>	<b>190</b>	<b>2,047,582</b>

<sup>1</sup> 2008 NJ Population data was obtained from The Annie E. Casey Foundation, KIDS COUNT Data Center.

<sup>2</sup> Other Race/Ethnicity includes American Indian and Alaskan Native, Asian, Native Hawaiian, Pacific Islander, and multi-racial children.

## Child Fatality and Near Fatality Review Board Initiatives

### ■ Reviewing cases within the year of incident

In the fall of 2009, the CFNFRB launched this initiative with the objective of making timely recommendations relating to systemic issues to be addressed by identified agencies. Achieving this goal will allow for more relevant recommendations regarding current trends or concerns and time to implement any warranted actions. The CFNFRB anticipates that all selected 2010 fatalities will be reviewed during the 2010 calendar year.

### ■ Sudden Unexpected Infant Death Case Registry (SUID-CR)

In July of 2009, New Jersey was one of five states selected by the Centers for Disease Control and Prevention to participate in the Sudden Unexpected Infant Death Case Registry (SUID-CR) pilot program, designed to enhance the data collection of all SUID cases. The pilot program will provide insight and understanding of the circumstances and events related to SUID fatalities, identify high risk characteristics and will contribute to the framework for a national SUID case registry. To assist the SUID pilot project, as of January 2010, the CFNFRB began using an enhanced data collection

tool created by the National Center for Child Death Review which captures additional variables regarding the child's health and mother's pre-natal care, the death scene and autopsy testing. The CFNFRB will maintain ongoing communication with the CDC and the Department of Health and Senior Services' Office of Injury Surveillance and Prevention (the grantee) through weekly, monthly, and quarterly feedback reports and collaboration sessions with other project participants.

#### ■ **Establishment of the Natural Death and SUID Sub-Committee**

In order to meet the SUID-CR grant timeline of reviewing SUID cases within three months of the infant's death, a sub-committee consisting of CFNFRB members was created to support the Board in conducting reviews. In doing so, the CFNFRB approved the participation of Dr. Thomas Hegyi, Director, and Dr. Barbara Ostfeld, Program Director at the SIDS Center of New Jersey, in the sub-committee.

If systemic or case handling issues are identified during the subcommittee reviews, a recommendation will be made to the CFNFRB to conduct a full review of the case.

#### ■ **Long Bone Study**

The CFNFRB received internal review board approval to study the number of children under one year of age examined in New Jersey hospital emergency rooms with long bone injuries, and discharged home, assessing whether the emergency room physician reported the suspicious injuries to DYFS for investigation. Hospital data will be compared to the DYFS automated data management system, NJSPIRIT, to determine if DYFS received a protective services report and if any of the children with the suspicious injuries (or their siblings) were involved in subsequent referrals pertaining to abuse after the initial ER visit.

The primary objective of this study is to determine the rates of reporting, investigating, and confirming child abuse among infants discharged home from the Emergency Department (ED) with suspicious fractures, and to identify which fracture types and patient risk factors are associated with child abuse. Bone fractures labeled suspicious include the humerus, radius, ulna, femur, tibia, fibula, and ribs. The secondary objective is to determine the frequency and type of suspicious fractures among infants discharged home from the ED, trend socio-demographic risk factors for suspected and confirmed abuse, and to assess the recurrence of suspected abuse among infants discharged home from the ED after being seen for a suspicious fracture.

The project is a retrospective study of electronic reports from the ED discharge summaries of infants seen with selected bone fractures; which are then crosschecked for reports of suspected abuse with information in the Department of Children and Families' NJSPIRIT (New Jersey Statewide Protective Investigation, Reporting, and Information Tool). The goal is to improve the reporting and investigation of suspicious fractures seen in hospital emergency rooms, in order to help prevent or reduce child abuse. A better understanding of referral patterns to DCF for high-risk injuries and child abuse would lead to the development of child abuse investigation guidelines and provider education efforts to improve child abuse investigations.

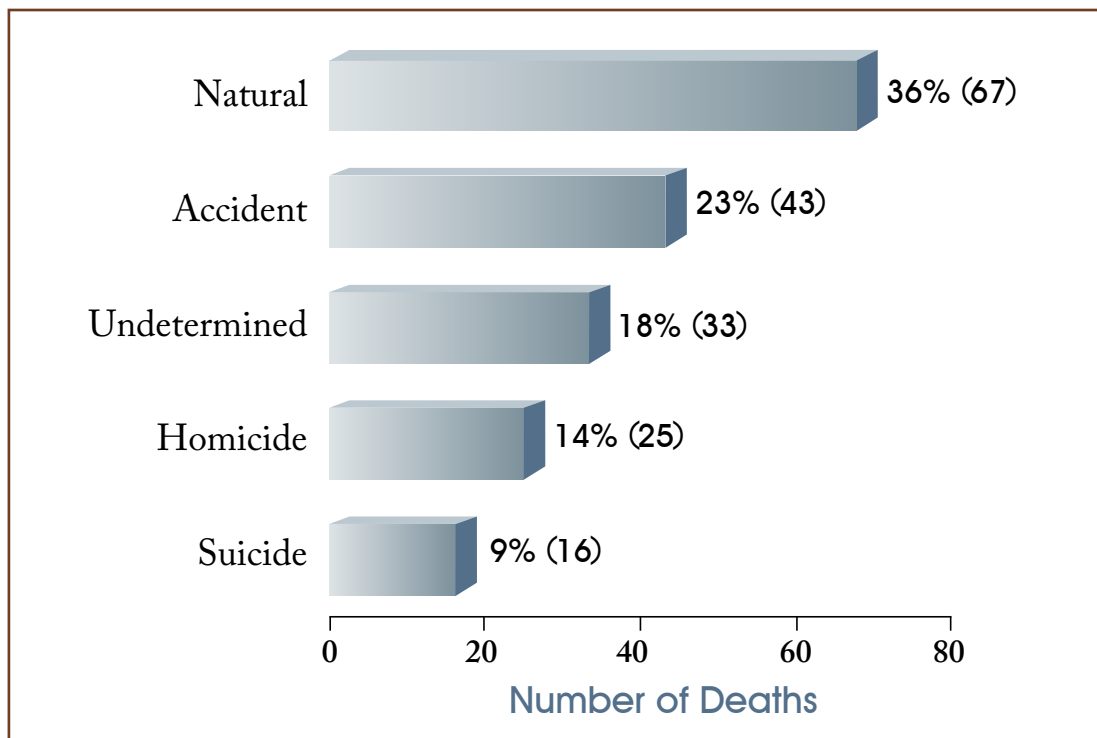
# Cause and Manner of Death

The New Jersey Office of the State Medical Examiner defines the cause of death as, “the underlying injury or disease that directly eventuates in death,” and the manner of death as a “classification of death” based upon the cause of death and the circumstances surrounding the death. The five categories of manner of death are natural, homicide, suicide, accident, undetermined.

The causes of death in the 184 fatalities reviewed included, medical illness, trauma and injury, asphyxia, sudden infant death, drowning, choking, drug and medication toxicity and overdose, smoke inhalation, firearm injury, and undetermined cause.

The manner of death in 36% (67) of the 184 fatalities reviewed was natural. In 23% (43) the manner was accident, in 18% (33) undetermined, in 14% (25) the manner was homicide, and in 9% (16) the manner was suicide.

*Figure 2-1* Manner of Death



The Fatalities by County table below (Table 2-1) illustrates the number of fatalities by manner of death, per county, and reviewed by either the Board or one of its regional teams. A finding of note on this table is that the number of fatalities was greatest in Essex County; however, with county child population factored in, Cumberland County has the highest child fatality rate with 20.5 children dying per 100,000. The county with the lowest child fatality rate was Middlesex County with 3.8 children dying per 100,000.

**Table 2-1** Reviewed Fatalities\* by County

COUNTY	MANNER OF DEATH						% Total Fatalities	Child Population** (< 18 Years)	County Reviewed Fatality Rate***
	Natural	Homicide	Accidental	Undetermined	Suicide				
ATLANTIC	4	0	5	1	0	5.43%	63,458	15.8	
BERGEN	0	1	3	3	1	4.35%	199,089	4.0	
BURLINGTON	2	1	1	1	1	3.26%	103,576	5.8	
CAMDEN	8	1	3	1	2	8.15%	127,060	11.8	
CAPE MAY	2	1	0	0	0	1.63%	18,671	16.1	
CUMBERLAND	1	4	0	2	1	4.35%	39,023	20.5	
ESSEX	20	7	4	6	0	20.11%	93,591	19.1	
GLOUCESTER	2	0	1	1	0	2.17%	69,219	5.8	
HUDSON	5	2	3	3	0	7.07%	122,267	10.6	
HUNTERDON	0	0	2	0	1	1.63%	31,194	9.6	
MERCER	3	1	2	1	1	4.35%	84,275	9.5	
MIDDLESEX	1	1	1	2	2	3.8%	184,078	3.8	
MONMOUTH	5	0	2	3	1	5.98%	155,965	7.1	
MORRIS	2	0	2	1	3	4.35%	117,519	6.8	
OCEAN	2	1	3	3	1	5.43%	131,316	7.6	
PASSAIC	6	3	3	2	0	7.61%	124,130	11.3	
SALEM	0	1	1	1	0	1.63%	15,689	19.1	
SOMERSET	0	0	4	0	0	2.17%	80,890	4.9	
SUSSEX	0	0	0	1	1	1.09%	36,960	5.4	
UNION	3	1	2	1	0	3.8%	129,216	5.4	
WARREN	1	0	1	0	1	1.63%	26,160	11.5	
<b>STATE TOTAL</b>	<b>67</b>	<b>25</b>	<b>43</b>	<b>33</b>	<b>16</b>	<b>100%</b>	<b>2,053,346</b>	<b>9.0</b>	

\* Reviewed Fatalities – fatality cases occurring in 2008 reviewed by the CFNFRB

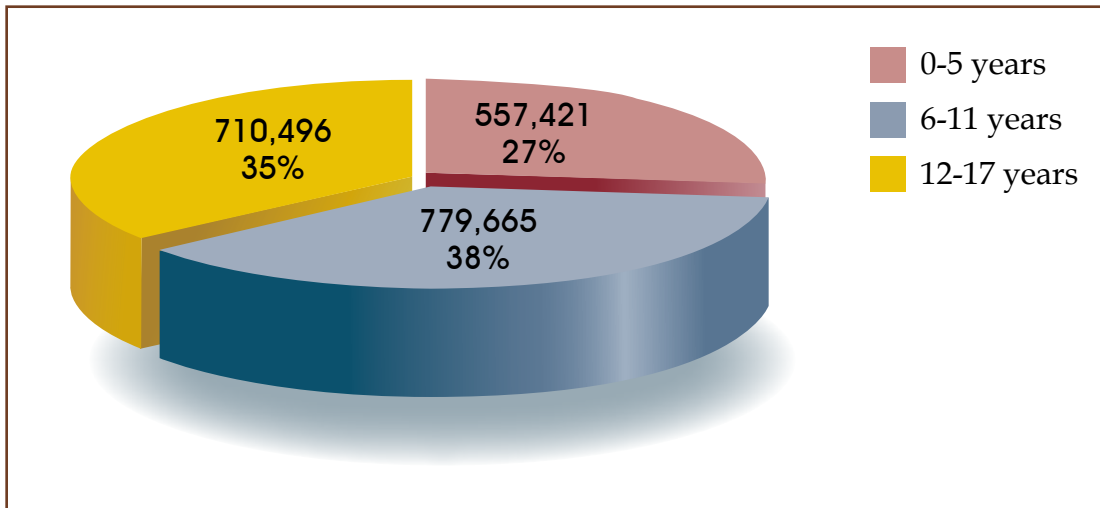
\*\* Population < 18 – from Population Division, U.S. Census Bureau, June 10, 2010.  
<http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/cnty06/cntyas.xls>

\*\*\* Reviewed Fatalities per County \* 100,000 / County Child (<18) Population

# Overview of Fatalities by Age Groups

In 2008, the total New Jersey child population of 2,047,582 was comprised of 27% ages 0-5, 38% ages 6-11, and 35% ages 12-17.<sup>1</sup> See Figure 3-1 below.

Figure 3-1 NJ Child Population by Age Group



Although national injury death rates have declined over the past two decades, unintentional injuries remain the leading cause of death for children ages 1–14. In New Jersey, the leading cause of the death among the 49 children ranging in age between one and 14 years old was unintentional injury, comprising 39% (19) of the total 49 fatalities reviewed of this age group.<sup>2</sup>

## Children at Risk

Infants and adolescents remain at higher risk of death, partly due to features inherent to their particular age groups. Infants remain vulnerable not only because of their young age, but also because of the occurrence of Sudden Infant Death Syndrome, which has yet to be attributed to a direct cause. Teenagers are vulnerable due to the prevalence of high-risk behaviors specific to this age group. The 2007 National Youth Risk Behavior Survey noted that over a thirty day span, 29% of high school students surveyed had ridden in a car with a driver who had been drinking alcohol, and 18% had carried a weapon. Over a 12-month span, 75% drank alcohol, 48% had been sexually active, and 7% had attempted suicide.<sup>3</sup>

<sup>1</sup> <http://datacenter.kidscount.org/data>

<sup>2</sup> <http://www.childstats.gov/AMERICASCHILDREN/phenviro6.asp>

<sup>3</sup> Eaton, et. al., Youth Risk Behavior Surveillance--United States, 2007, CDC, [www.cdc.gov](http://www.cdc.gov), <http://www.aacap.org/>



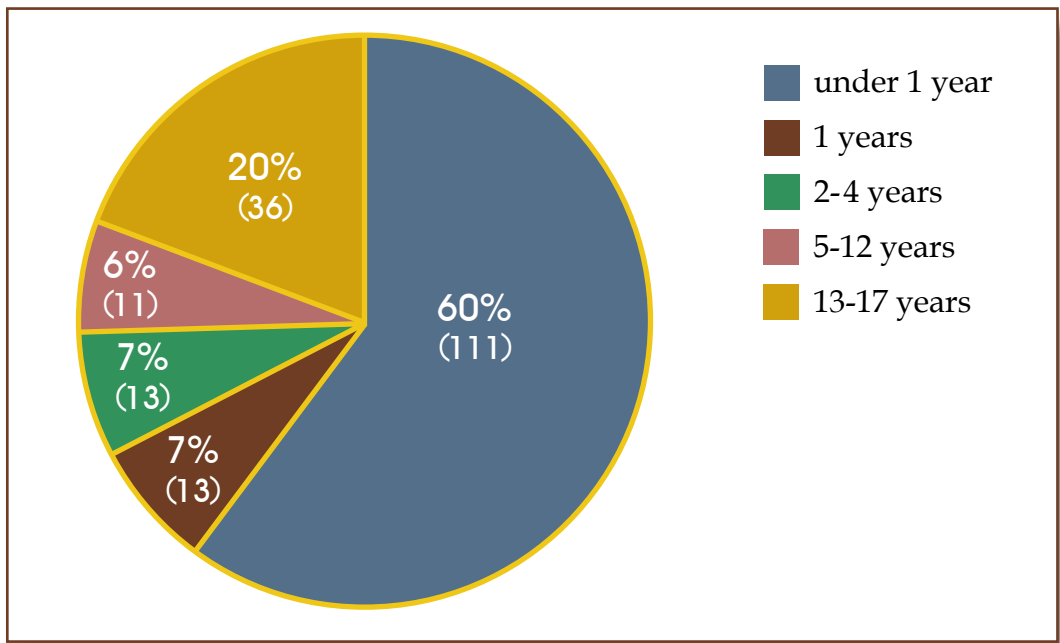
In the infant deaths reviewed, the infant's inability to protect themselves may have been a factor, regardless if the death was a result of SUID, or child abuse or neglect. For example, an infant developmentally unable to reposition itself may asphyxiate when placed face down in soft bedding. Almost all the teen deaths that were reviewed resulted from risky behavior and were preventable.

A death is preventable if an individual or community entity (caregiver, medical, educational, legal, environmental, mental health or child welfare) could have reasonably prevented the death.

A total of 60% (111) of the 184 fatalities reviewed in 2009 were infants under one year old, with the majority being four months old or younger. The next largest age group was that of teens ages 13-17, representing 20% (36) of the child fatalities reviewed, as shown in the Figure 3-2 below.

The remaining ages included in the child deaths reviewed were 7% (13) age one year old, followed by 7% (13) ages 2-4 years old, and 6% (11) ages 5-12 years old.

Figure 3-2 | Reviews by Age Group



## Infant Deaths

The CDC reports one of the leading causes of death in infants under one year old is Sudden Unexpected Infant Death (SUID), attributing to approximately 4,600 infant fatalities each year in the United States. This type of death occurs suddenly, in infants younger than one year, during sleep time, and with no immediately clear cause of death.

New Jersey law mandates (N.J.S.A. 52:17B-88.10 and N.J.S.A. 52:17B-86i) that where the suspected cause of death of a child under one year of age is Sudden Infant Death Syndrome (SIDS) or the child is between one and three years of age and the death is sudden and unexpected, a complete death scene investigation, clinical history review and autopsy must be conducted to identify the cause and manner of death. Once the investigation and autopsy are completed, these sudden unexpected deaths fall into one of two categories, either explainable, such as cases of suffocation, hyper/hypothermia, poisoning, homicide, metabolic disorders, etc. Or, unexplained, such as with unknown or undetermined causes, and with Sudden Infant Death Syndrome (SIDS).

SIDS is defined as the sudden death of an infant less than one year old, where after a complete investigation and autopsy, the cause of death cannot be explained or attributed to a specific cause. SIDS accounts for more than half of the sudden unexpected infant deaths in the United States.

The New Jersey Office of the State Medical Examiner defines the term Sudden Unexpected Infant Death (SUID) as “used for a child under the age of one when some circumstantial information or diagnostic finding exists that suggests an explanation or the possibility of an explanation for the death. The manner of death of SUID cases may be natural or undetermined. The term Sudden Unexpected Death of a Child (SUDC) is applied to children from one to three years of age who died without the determination of a clear cause for the death. The manner of death of SUDC cases may be natural or undetermined.”

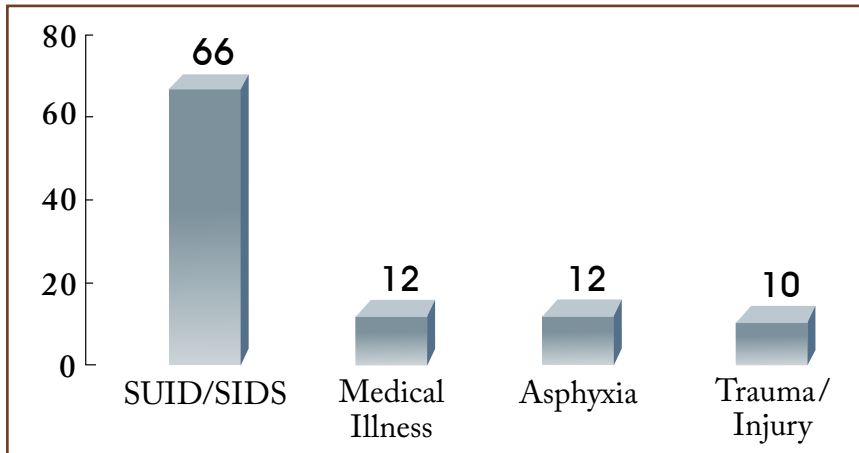
### Leading Causes of Infant Deaths

The leading cause of infant deaths reviewed in 2009 was SUID and SIDS; comprising 59% of the 111 infant deaths reviewed. SUID deaths represented 32% (36) and SIDS 27% (30), see Figure 4-1. The second leading cause of death in infants was evenly distributed between accidental asphyxiation or suffocation in 11% (12) of the deaths, and medical illness in another 11% (12). The medical deaths included conditions such as congenital heart disease, or complications of prematurity. (Encephalopathy related to cardiac arrest in a resuscitated unresponsive infant was the cause of death in one case).

Illness and accidental asphyxia were followed by blunt force trauma injuries, which made up the third most common cause of death reviewed in infants. The injury related deaths were associated with abuse, and were seen in 9% (10) of the infant deaths reviewed. The remaining infant deaths included 4% (4) caused by drowning, 3% (3) by undetermined causes, followed by drug overdose, encephalopathy, hyperthermia and choking, each less than 1% (1).

Figure 4-1

## Leading Causes of Reviewed Infant Deaths



A total of 13 of the 111 infant deaths reviewed were classified as homicide; including all 10 instances of blunt force trauma injuries, two drowning deaths, and one stabbing death. These infant homicides will be discussed in the DYFS section.

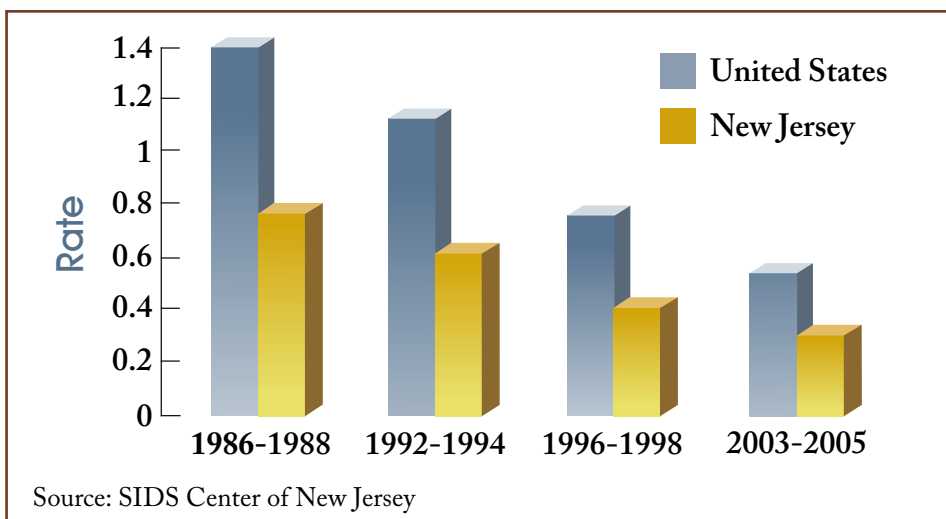
### Sudden Unexpected Infant Death and Sudden Infant Death Syndrome

The Centers for Disease Control (CDC) reports national SIDS rates have declined significantly since the early 1990's. Figure 4-2 below published by The SIDS Center of New Jersey reports a similar trend in New Jersey SIDS rates, with a steady decline in SIDS fatalities from 1986 through 2005.

The Centers for Disease Control (CDC) reports national SIDS rates have declined significantly since the early 1990's. However, research has found the decline can be explained by an increasing number of deaths classified as SUID fatalities.

Figure 4-2

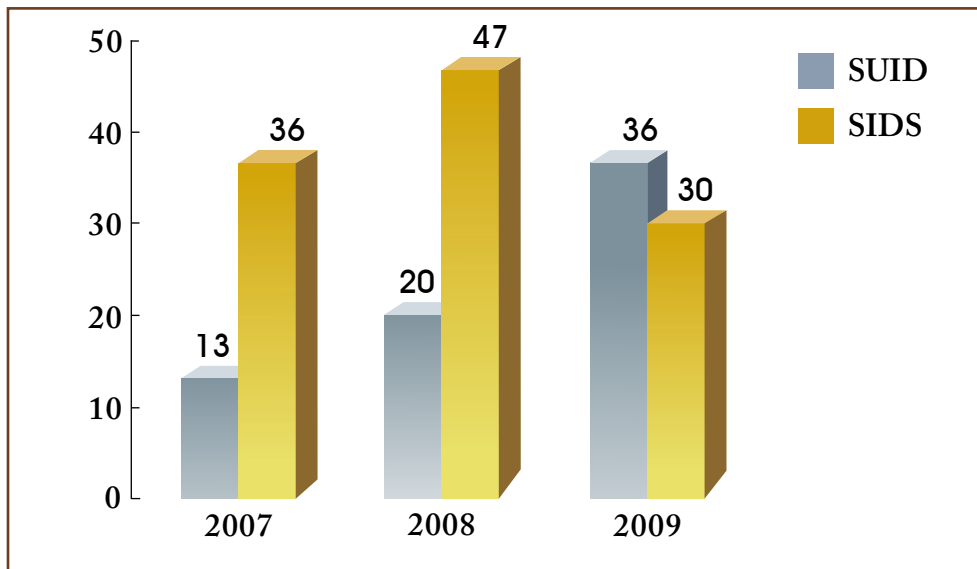
## Declining SIDS Rates in United States and New Jersey based on the number of SIDS Deaths per 1,000 live births.



However, the CDC reports research has found the decline in SIDS deaths since 1999 can be explained by an increasing number of SUID fatalities, such as with cases of suffocation, overlay, or wedging in co-sleeping situations. This change in classification of SIDS to SUID can be attributed to changes in how investigations are conducted, and by the identification of criteria used in making SUID determinations. For example, after investigation, more deaths may be attributed to accidental suffocation than to SIDS, causing a decrease in SIDS related fatalities.

Figure 4-3 below demonstrates a shift in the number of New Jersey SIDS and SUID deaths reviewed, similar to the shift from SIDS deaths to SUID deaths noted in CDC research findings. Note the decrease in New Jersey SIDS deaths reviewed by the CFNFRB from 2007 to 2009, while an increase is seen in the SUID deaths reviewed for the same years.

**Figure 4-3** New Jersey SUID and SIDS by Year of Review



### SIDS / SUID Infant Deaths by County

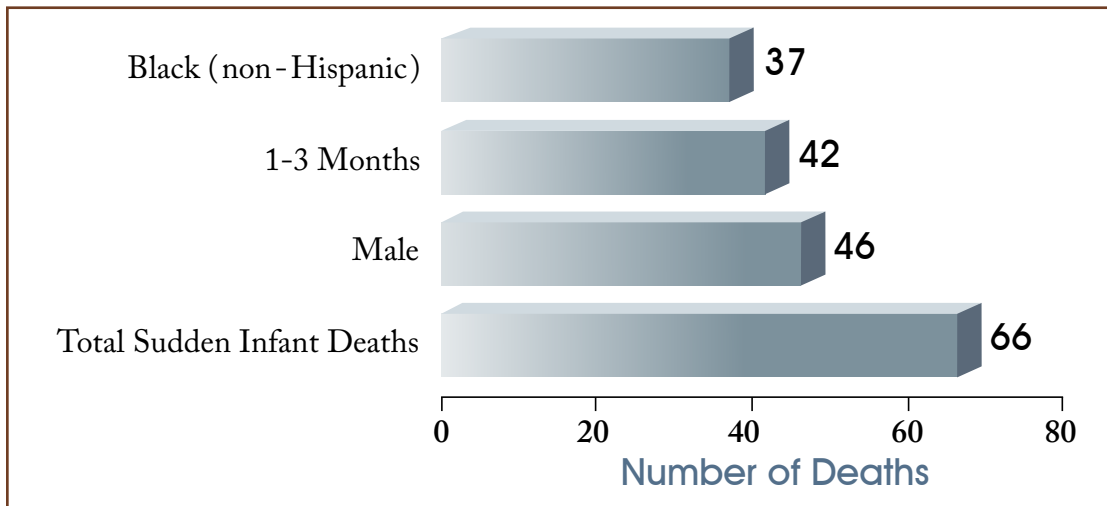
Infant deaths reviewed in 2009 due to SUID and SIDS, occurred in a higher concentration in the northern region of the state, with the highest number of sudden infant deaths in Essex County with 20 infant deaths, followed by Hudson and Monmouth Counties with five infant deaths each.

### Sudden Infant Deaths by Age, Race, and Gender

Nationally, Black (non-Hispanic) male infants, ages 1-3 months old, are found in greater prevalence among cases of sudden infant deaths according to the American Academy of Pediatrics.

In New Jersey, males were at greater risk of sudden infant death, as were Black (non-Hispanic) infants, and those ages 1-3 months old. The CFNFRB reviewed a total of 66 sudden infant deaths in 2009, and found 69% (46) were male, 63% (42) were age 1-3 months old, and 56% (37) were Black (non-Hispanic), as shown in Figure 4-4 below.

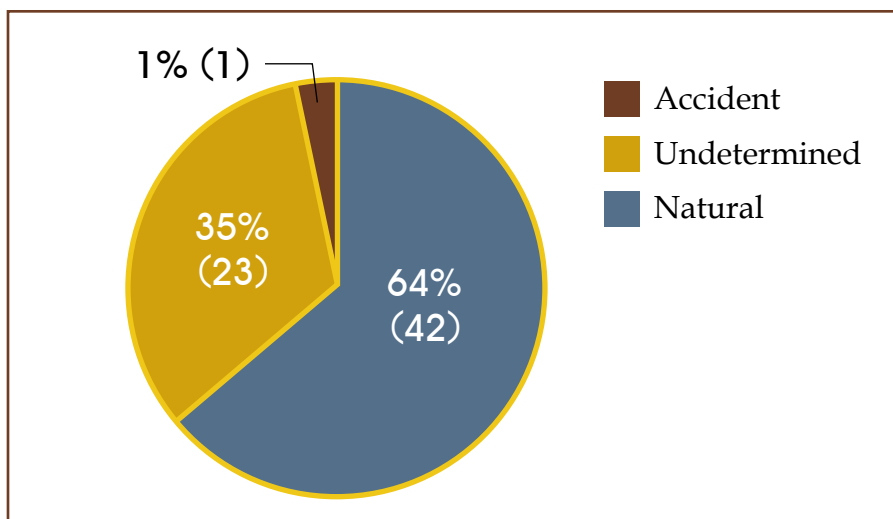
**Figure 4-4** Sudden Infant Deaths / Age, Race, Gender



### SUID and SIDS Deaths by Manner

In the 66 SUID and SIDS deaths reviewed in 2009 by the CFNFRB, the manner of death was determined to be natural in 64% (42) of the infant deaths; undetermined in 35% (23); and accidental due to overlay while co-sleeping in 1% (1) of the cases reviewed. See Figure 4-5 below. (Additional deaths where overlay was involved are discussed in the infant cause of death section).

**Figure 4-5** SUID/SIDS Infant Deaths by Manner

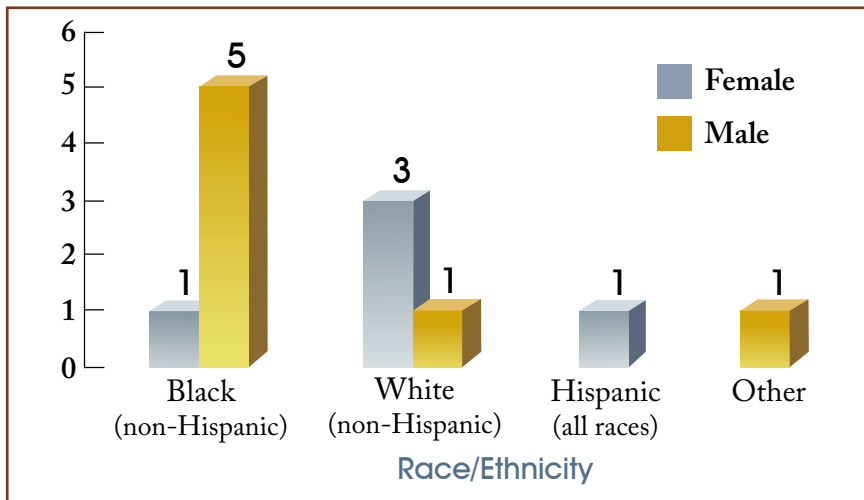


## Infant Deaths Due to Positional Asphyxia

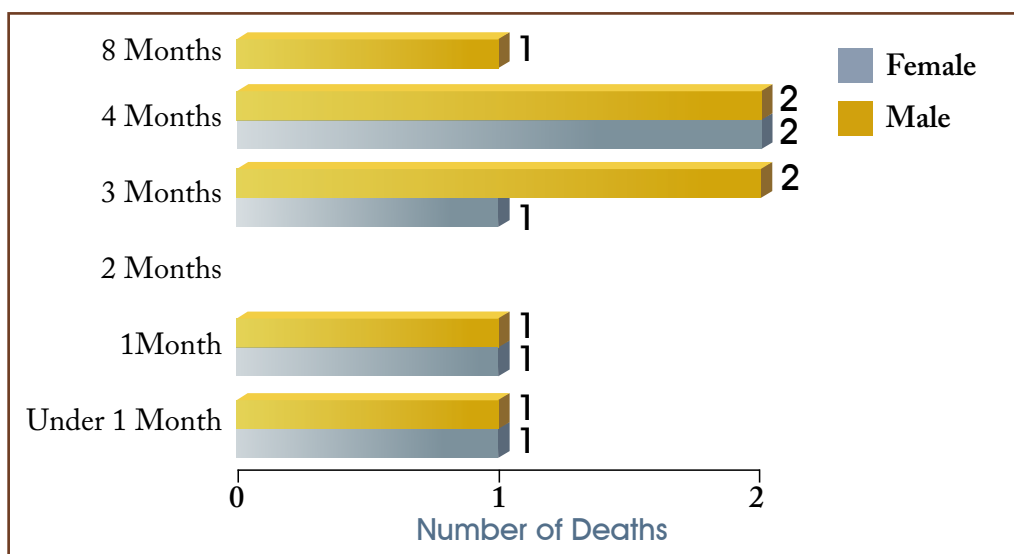
Death due to suffocation of an infant who is sleeping with a parent or sibling is the most common form of positional asphyxia. Accidental asphyxia deaths, as those found in 11% (12)<sup>4</sup> of the cases reviewed involved preventable scenarios, which included positional suffocation, overlay of a co-sleeping infant, wedging of the infant between a parent and couch cushion, or infants found face down on soft pillows or beddings. (Safe sleep position and location are discussed further in the infant death risk section.)

Black (non-Hispanic) male infants ages 3-4 months old were the most frequent victims of infant asphyxia deaths reviewed, as Figures 4-6 and 4-7 demonstrate.

**Figure 4-6** | Accidental Infant Asphyxia by Gender and Race/Ethnicity (2008)



**Figure 4-7** | Accidental Infant Asphyxia by Gender and Age



<sup>4</sup> In one death, the cause was classified as SUID due to overlay; in an additional death, asphyxia was the cause of death, but classified as a homicide, therefore not compared in positional asphyxiation data.

## Infant Death Risk Factors

The American Academy of Pediatrics (AAP) identifies a number of risk factors related to SUID and SIDS fatalities, which include:

- Co-sleeping – sleeping with a parent or sibling
- Soft bedding, toys, blankets or pillows in the sleep area
- Prone, or face down positioning for sleep
- Overheated or excessively warm room temperature at sleep location
- Unsafe sleep locations such as held in sleeping parent’s arms, air mattress, adult bed, couch, or other furniture

In 56% (37) of the 66 SUID and SIDS infant deaths reviewed in 2009, there were two or more environmental risk factors occurring simultaneously.

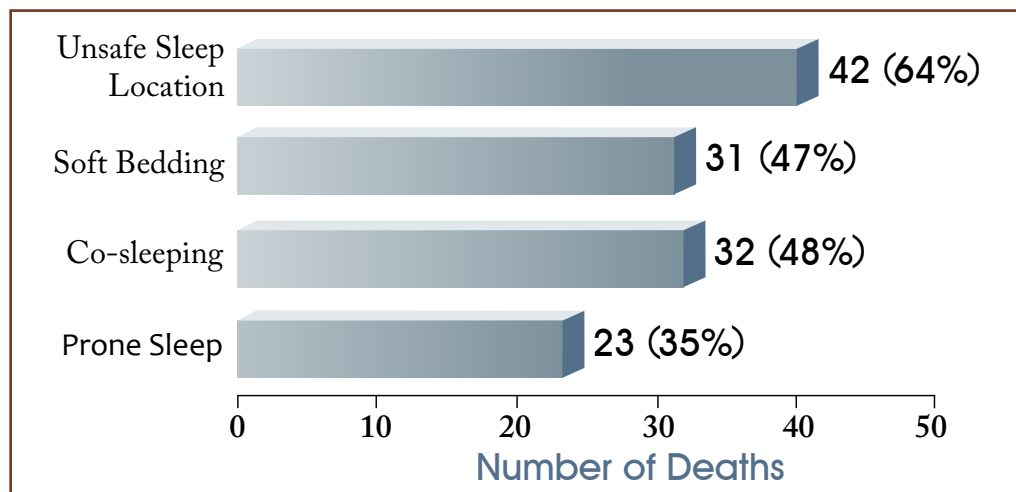
As Figure 4-8 below demonstrates, 64% (42) of the infant deaths reviewed attributed to SIDS or SUID included an unsafe sleep environment, such as an adult bed, a couch, or car seat. Co-sleeping with an adult or sibling was found in 48% (32) of the infant deaths reviewed, while soft bedding, pillows, or toys were found in 47% (31). In 35% (23) of the cases, the infant was placed face down or prone for sleep. An appropriate sleep location such as a crib or bassinet was used in 32% (21) of the infant deaths reviewed.

64% of New Jersey infant deaths reviewed in 2009 involved infants who were sleeping in unsafe settings, such as an adult bed, car seat, or sofa.

In 4% (3) of the deaths, the sleep location was unknown due to absent or conflicting information from the death scene investigation.

\*An additional 11 infant deaths not classified as SIDS or SUID, were declared an accident in manner of death, with asphyxia as the cause of death, due to suffocation by overlay while co-sleeping with a parent or sibling.

**Figure 4-8** | Sleep Environment Risk Factors



While excessively warm room temperature is another known SIDS risk factor, the CFNFRB could not fully evaluate this variable in the fatalities reviewed due to incomplete death scene investigation tools which lacked room temperature in greater than 50% (38) death scene investigation reports. Of the remaining 33 reports which did include room temperature, 29 noted ambient temperature between 72 and 84 degrees during the death scene investigation.

## Risk Reduction

The American Academy of Pediatrics (AAP) Task Force on Sudden Infant Death Syndrome has issued guidelines for reducing known risk factors for SIDS:

- “Back to Sleep.” Back sleeping is associated with the lowest risk for SIDS.
- Use a crib or bassinet with firm mattress and well-fitting sheet, free from pillows, blankets, toys, or clutter.
- Maintain a smoke free environment.
- Never care for an infant while under the influence of drugs or alcohol.
- Be aware of over heating, maintaining an even comfortable room temperature.

## IS “BACK TO SLEEP” ENOUGH?

On average, one infant per month died in New Jersey in 2008 as a direct result of suffocation, with overlay, co-sleeping, and wedging listed as the cause of death by the Medical Examiner. Thirty-two infant deaths caused by SIDS or SUID involved co-sleeping, with 13 of those including a notation on the Medical Examiner report stating that overlay during sleep was a contributing factor, or could not be ruled out as a contributing factor in the cause of death.

Safe sleep is about more than the infant’s position during sleep.

Placing infants to sleep on their back is recognized world wide as a means of risk reduction for SIDS deaths. Simply said, “back to sleep” may not be enough. “Back to sleep” for instance, on a couch, between two adults, or with siblings, does not eliminate risk for the infant. It is important to emphasize the use of a crib or bassinet, free from stuffed toys, clutter, pillows, and quilts. Room temperature and air quality are important as well. The priority is to create a safe environment which minimizes the chance of an infant not waking enough to re-position their head or face if breathing or airflow is affected or obstructed. “Back to sleep” works best in a crib or bassinet, alone, with no toys or clutter, free from smoke or pollutants, and with a moderate room temperature.

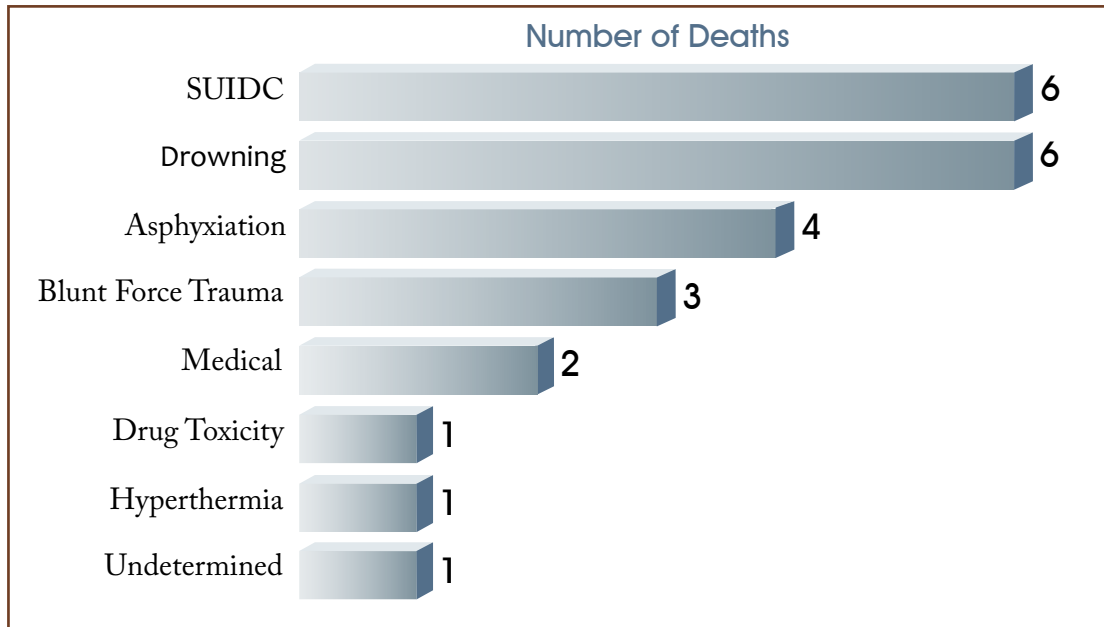
In 2008 an average of one infant per month died in New Jersey as a direct result of accidental or positional asphyxiation



## Ages 1–3 Years - Cause and Manner of Death

Twenty-five children ages 1-3 reviewed in 2009 died unexpectedly, with six dying of unknown causes (Sudden Unexplained Death in Childhood), followed by drowning (which will be discussed in the Accident section), accidental asphyxia, and intentional blunt force trauma.

Figure 5-1 | Ages 1-3 Deaths by Cause



### SUDC in Children Ages 1-3

Much like SIDS, SUDC is a finding of exclusion, when all other causes of death have been ruled out. Where as SIDS applies to infants less than one year old, SUDC is identified as a cause of death for children who are ages one through three years old, and whose deaths cannot be explained after a complete autopsy, death scene investigation, and review of medical history.

SUDC deaths are rare, occurring nationally in incidence of 1.2 deaths per 100,000 children, compared to 54 SIDS deaths per 100,000 children according to the Centers for Disease Control and Prevention (CDC) 2005 data.<sup>5</sup>

Risk factors specific to SUDC have yet to be established, although child health specialists recommend guidelines similar to SIDS risk reduction as precaution or preventative measures. Of the six SUDC fatalities reviewed in 2009 by the CFNFRB, none involved co-sleeping with a parent or sibling. Two children were sleeping in a crib at the time of death, one was sleeping in an adult bed, one was sleeping in a toddler bed, one was sleeping in a playpen, and one was sleeping on a soft couch. The manner of death in five of the SUDC fatalities was natural, and undetermined in one.

<sup>5</sup> <http://wonder.cdc.gov/mortsql.html>

## Other Causes of Death Ages 1-3

Asphyxia was the cause of death in four fatalities ages 1-3, with two attributed to choking or airway obstruction, one attributed to accidental hanging involving the cord from mini-blinds, and one attributed to suffocation when a child became trapped in a box used as a toy box. Each death was deemed an accident in manner.

Blunt force trauma or injury was the cause of death in three fatalities, in each case with injuries consistent with abuse, and each deemed to be homicide in manner.

Medical problems were the cause of death in two fatalities reviewed for this age group, including complication of seizure disorder, and an intestinal blockage after hernia repair surgery. The manner of death in both of these fatalities was identified as natural.

In one death caused by hyperthermia, a three year old child was left unattended in a vehicle for three hours, exposed to high ambient temperature. The manner of death was accident.

One death was caused by adverse effects of drug exposure when a three year old child ingested a small amount (approximately one tablet) of prescription pain medication. The manner of death was deemed accident.

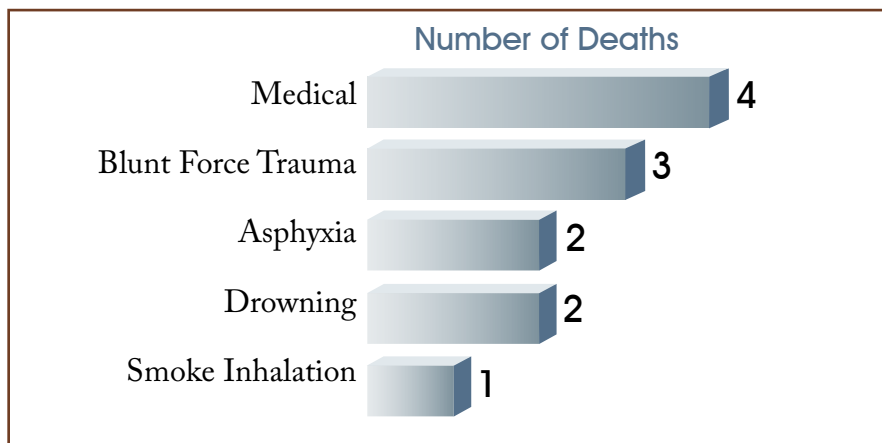
One death with an undetermined cause and manner was reviewed involving a two year old child who was found unresponsive in his crib, with no signs of injury, and no illness, other than an elevated temperature of 101 degrees. The manner of death was identified as undetermined as well.

## Ages 4–12 Years Old - Cause and Manner of Death

The leading cause of death reviewed in children ages 4-12 was medical illness, including asthma, muscular dystrophy, encephalopathy, and gastric obstruction. The manner of death in each of these was natural. The remaining causes of death reviewed in this age group were; blunt force trauma (3), asphyxia (2) drowning (2), and smoke inhalation (1).

Figure 6-1

Ages 4-12 Deaths by Cause



The three fatalities reviewed in this age group caused by blunt force trauma, involved 2 children whose injuries were inflicted intentionally, and one child (age six) who drove an ATV (all terrain recreational vehicle) unsupervised, and was struck by oncoming traffic. The manner of death in two of these was deemed homicide, and in the third, involving the ATV, the manner was accidental.

The two drowning deaths reviewed involved one youth age six, and one youth age 12, with both deemed an accident in manner.

Two deaths reviewed in this age group caused by asphyxia involved accidental hanging, when one youth age eight, tied himself to a banister while playing, and a second youth age five, became tangled in a sheet after hanging it from overhead pipes while trying to make a swing. The manner of death in both identified as accident.

In one death the cause of death was smoke inhalation, when a 10 year old child was overcome during a house fire that was classified as arson. The manner of death was deemed as homicide.

## Teen Deaths

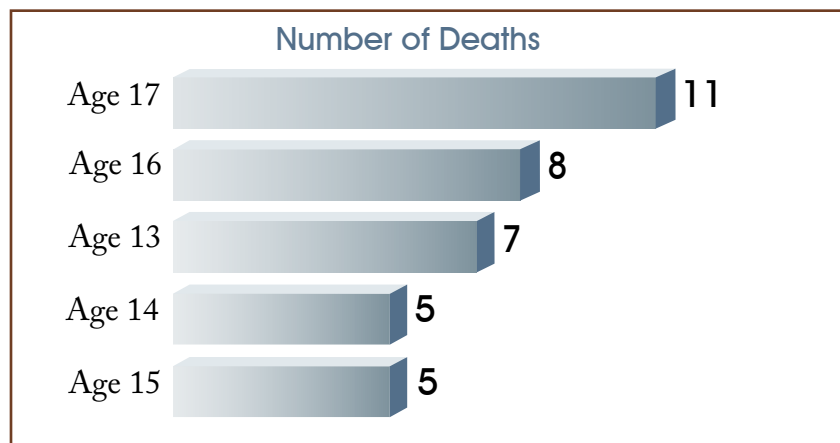
More than 13,000 teens died in the United States in 2006, at a rate of 64 deaths per 100,000.<sup>6</sup>

According to the Institute of Medicine, in 2008 the three leading causes of teen death in the United States were motor vehicle accident, homicide, and suicide.

### Teen Deaths by Age

In 2009, 20% (36) of the fatalities reviewed involved youth ages 13-17. More than half of the teen deaths (19) were 16 – 17 years old.

*Figure 7-1* | Teen Deaths by Age

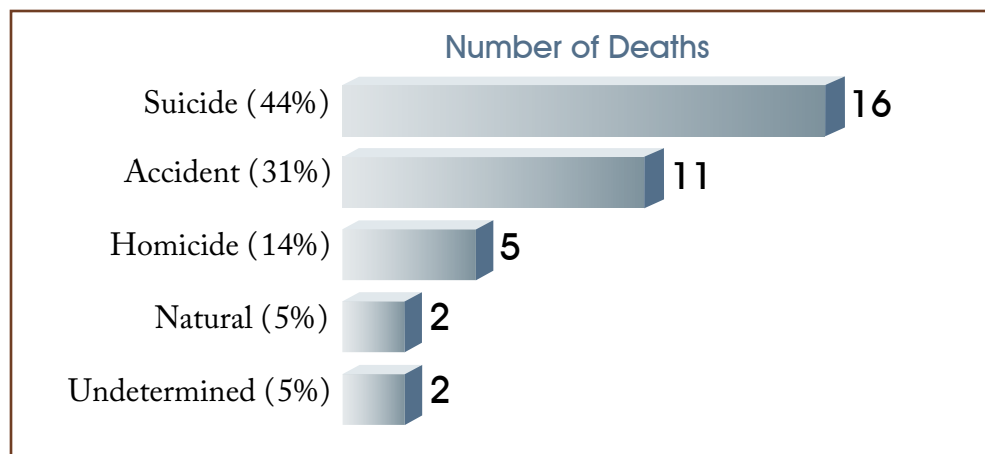


<sup>6</sup> <http://www.childstats.gov/AMERICASCHILDREN/phenviro7.asp>

## Teen Deaths by Manner

Suicide was the leading manner of death in teen deaths reviewed in 2009, comprising 44% (16) of the fatalities for this age group: 31% (11) were due to accidents such as drowning; while 14% (5) were due to homicide; 5% (2) were natural; and 5% (2) were undetermined manners. This disproportionate ratio may be attributed in part to the statutory review criteria for child deaths. See Table 7-2.

Figure 7-2 | Teen Deaths by Manner



## Teen Deaths by Cause

Hanging was the leading cause of death in the teens reviewed in 2009, followed by overdose, firearms, drowning, medical illness, asphyxia, and burns.

In the 16 adolescent fatalities where the manner of death was suicide, the causes of death included, hanging (9), overdose (3), firearms (3) and drowning (1).

The 11 fatalities with an accidental manner of death included, drug and alcohol overdose (5), drowning (3), burns from a campfire (1), asphyxia drowning during a motor vehicle accident (1), and asphyxia involving neck and chest compression, when a shelf fell on a 13-year-old youth with severe cerebral palsy.

The five fatalities with homicide as the manner of death included causes of death attributed to, firearms (4), and asphyxia by strangulation (1).

The two fatalities with a natural manner of death included asthma as the cause in one death, and the second caused by aspiration pneumonia with a contributing cause of drug abuse.

The cause of death in the two fatalities with undetermined manners included one hanging, where it could not be determined if the act was horseplay or suicidal intent, and a drug overdose that could not be ruled as accidental, or intentional, resulting in an undetermined manner, although this particular youth had a history of a previous suicide attempt, and diary entries which expressed suicidal ideations.

## Teen Deaths by Motor Vehicle Accident

In New Jersey, 59 teen deaths (36 drivers and 23 passengers) were due to motor vehicle accidents in 2008, representing a decrease in fatalities from 73 deaths in 2006.<sup>7</sup>

New Jersey efforts that have contributed to this decline include programs like the graduated driver's license (GDL) instituted by New Jersey in 2001, to provide teen drivers with a progressive driving exposure allowing time for driving skill development, and the New Jersey Teen Driver Safety Study Commission, whose mission is to evaluate teen motor vehicle safety, and make recommendations to help reduce the number of teen driver-related injuries and deaths.<sup>8</sup>

The CFNFRB does not review motor vehicle deaths as a rule, unless the youth was receiving services from DYFS at the time of death, or if the youth had a positive result for drugs or alcohol in the autopsy toxicology report.

Between 2007 and 2008, the CFNFRB reviewed three teen motor vehicle fatalities involving positive toxicology reports; none in 2007 and three in 2008. In 2009, the CFNFRB reviewed no teen motor vehicle fatalities involving alcohol but did review one motor vehicle related incident involving a teen with positive toxicology. The cause of death was attributed to accidental asphyxia, when a youth driving an all terrain vehicle (ATV) crashed, pinning the youth in a muddy ditch. The autopsy toxicology report indicated a presumptive positive result for marijuana, although it could not be determined how long before the accident the last use occurred.

Although the Board only reviewed one teen fatality with positive toxicology, nationally, fatal crashes involving drivers under the influence continues to be a problem. The National Center for Statistics and Analysis (NCSA), an office of the National Highway Traffic Safety Administration (NHTSA), reported that in 2008, 31% of drivers age 15 to 20 years old who were killed in crashes had a blood alcohol concentration (BAC) of .01 or higher, and 25% had a BAC of .08 or higher. Additionally, alcohol involvement in fatal crashes is higher among males than females with 26% of male drivers under the influence compared to 13% of female drivers.<sup>9</sup> However, the NHTSA estimates that drinking age laws have reduced traffic fatalities involving drivers 18 to 20 years old by 13%.

<sup>7</sup>New Jersey Office of the Attorney General <http://www.state.nj.us/lps>

<sup>8</sup><http://www.nj.gov/oag/hts/teen-driver-report-updates.html>

<sup>9</sup><http://www-nrd.nhtsa.dot.gov/Pubs/811169.PDF>

## Suicide Deaths

The National Institute of Mental Health (NIMH) reports suicide is the third leading cause of death among adolescents in the United States. Nationally, adolescent White (non-Hispanic) males are most at risk for suicide. Although females tend to have a higher frequency of suicide attempts, more males have a fatal outcome due to choosing more lethal means, such as firearms.<sup>10</sup>

In 2007, 6.9% of high school student surveyed through the Youth Risk Behavior Survey indicated they had attempted suicide in the last 12 months, and 14.5% had seriously considered attempting suicide<sup>11</sup>. The warning signs and risk factors associated with adolescent suicide include: depression, previous suicide attempts, recent losses, frequent thoughts about death, and the use of drugs or alcohol.<sup>12</sup>

### Adolescent Suicide Risk Factors

- Youth or family history of mental illness, such as depression or bipolar disorder
- Family or relationship crisis

## Suicide by Age, Race, and Gender

In 2009 the CFNFRB reviewed 16 deaths in which suicide was the manner of death. All 16 youth were between the ages of 13-17 years old. The gender was evenly split with 50% (8) of the youth being male and 50% (8) being female. The racial composite of the group was 63% (10) White (non-Hispanic), 25% (4) Hispanic (all races), 6% (1) Black (non-Hispanic), and 6% (1) being of other decent.

According to KIDS COUNT data center, the child demographic composite in New Jersey in 2008, was 51% male, and 49% female, 54% White (non-Hispanic), 21% Hispanic (all races), 15% Black (non-Hispanic), 8% Asian, and 2%, of other decent. The racial composite of New Jersey youth reviewed who died by suicide showed a greater proportion of White (non-Hispanic) youth, with a significantly lower ratio of Black (non-Hispanic) youth, when compared to the demographic make up of New Jersey youth in 2008.

## New Jersey Adolescent Suicide by Cause

The cause of death in 56% (9) of the adolescent suicide fatalities was due to hanging, an often planned, less impulsive act than by other means. In 19% (3) the cause of death was overdose, in 19% (3) the cause of death was due to firearms, and in 6% (1) the cause of death was drowning. An additional 9 teen deaths involved drug use, and are detailed further in the substance abuse section. See Figure 7-3.

<sup>10</sup> <http://www.nimh.nih.gov/index.shtml>

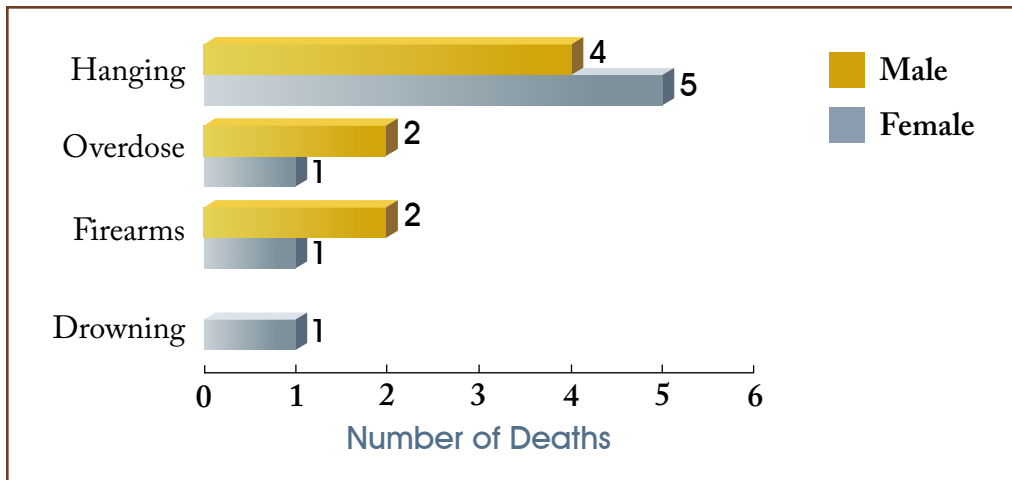
<sup>11</sup> <http://www.nimh.nih.gov/index.shtml>

<sup>12</sup> <http://www.aacap.org/>

<sup>13</sup> <http://www.cdc.gov/>

Figure 7-3

## Suicide Deaths by Cause



### New Jersey Adolescent Suicide Risk Factors

In the 16 adolescent suicide deaths reviewed by the CFNFRB, the following risk factors were observed at the noted rates:

- **Family / Relationship Crisis** - 81% (13) included family or relationship crisis or conflicts, four of which included domestic violence.
- **History of Mental Illness** - 69% (11) had a known history of mental illness, and carried psychiatric diagnoses. 50% (8) had histories of psychotropic medication treatment. 31% (5) had histories of inpatient psychiatric treatment, with three youth having been discharged within 30 days before the death. In these three cases the board found the records failed to reflect continuity in discharge planning and after care follow up.
- **Drug, Alcohol, Medication Abuse** - 56% (9) included histories of substance abuse, including illicit drugs, abuse of over the counter medications, and abuse of prescription medications.
- **Physical / Sexual Abuse** - 44% (7) included histories of physical or sexual abuse. Of these, five histories included sexual abuse; which, in one case not discovered until after the youth's death when the autopsy revealed injuries indicative of chronic sexual assault. The remaining two fatalities with abuse histories included reports of physical abuse.
- **Prior Attempts** - 19% (3) had a known history of prior attempts, in fact multiple attempts of three or more times occurred in all three cases.
- **Suicide Attempts by Loved One** - 6% (1) youth had lost a parent to suicide.

31% of the adolescent deaths by suicide had histories of inpatient psychiatric treatment, with 19% having been discharged within 30 days before the fatal event.

## Other Significant Features

Additional features beyond the national risk indicators, found in common among the New Jersey suicide deaths reviewed included:

- **In 75%, (12)** youth had evidenced prior suicidal ideations, including suicidal threats, diary or journal notes and drawings of suicidal themes, and conversations with others about suicide.
- **In 37% (6)** of the deaths due to suicide, the youth had a history of self-mutilation or self-injurious behavior, and one youth had a history of fire setting behavior.
- **In 31% (5)** youth had treatment histories with multiple service providers, including emergency assessments, inpatient treatment, outpatient treatment, group home or residential treatment facilities, or clinical case management.
- **In 19% (3)** the youth received services from DCF's Division of Child Behavioral Health Services, including, Mobile Response Stabilization Services, clinical case management, therapeutic out of home placements, and outpatient or in home therapy linkage.

### Teen Deaths and Substance Abuse

#### Substance Abuse Remains a Major Problem

- An estimated 19.9 million Americans aged 12 or older were current users of an illicit drug in 2007. This estimate represents 8% of the population.
- An estimated 70.9 million Americans reported being current users of a tobacco product in 2007, a prevalence rate of 28.6% of the population 12 years and older.
- Vicodin is one of the drugs most commonly abused by adolescents. In 2008, 15.4% of 12th graders reporting using a prescription drug for non-medical purposes in the last year.<sup>13</sup>

The United States Department of Health and Human Services reports that in 2008 26% of high school students reported alcohol use in episodes of "binge drinking."

Regular cocaine and heroin use was estimated between 2% and 3% of high school students in 2007.

Abuse of prescription and over the counter medication affects an estimated 5% - 7% of students. School based education and services remain the most successful intervention for adolescent substance abuse according to the Annie E Casey Foundation.

<sup>13</sup> [www.nida.gov](http://www.nida.gov)



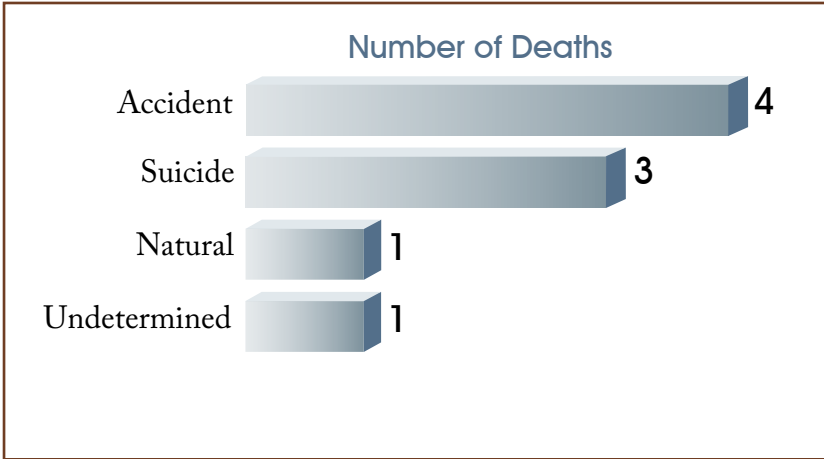
# Teen Deaths and Substance Abuse

In 6% (11) of the fatalities reviewed in 2009, the death involved the use of illicit drugs, over the counter medication, or prescription medication, including marijuana, ecstasy, prescription pain medication, prescription psychotropic medication, aerosol inhalants, cocaine, heroin, and methadone. Nine of those 11 deaths reviewed were adolescents.

In 25% (9) of the teen deaths reviewed, the cause of death involved drug, alcohol or medication abuse, overdose or toxicity. In 44% (4) of the teen deaths involving substance abuse, the manner of death was ruled an accident, in 33% (3) the manner was suicide, in 33% (3) the manner was undetermined, and in 1% (1) the manner of death natural, due to aspirated pneumonia with drug abuse as the contributory cause. See Figure 7-4.

Of the nine teen deaths reviewed caused by substance abuse, 88% (8) had histories of treatment services specific to substance abuse, including, both inpatient and outpatient treatment.

**Figure 7-4** | Teen Substance Abuse Deaths



Of the nine teen deaths caused by substance abuse toxicity or overdose, 88% (8) had histories of treatment services specific to substance abuse, including, both inpatient and outpatient treatment. 55% (5) youth were diagnosed with psychiatric disorders, such as bipolar disorder, in addition to a specific substance abuse diagnosis, such as poly-substance dependence. 44% (4) of those youth had histories of multiple or repeated treatment engagement.

## Accident Deaths

The CDC reports about 20 children die every day from a preventable injury – more than die from all diseases combined. Injury remains the leading cause of death for children ages 1 - 17.

The death rate for males is almost two times the rate for females, and males have a higher injury death rate compared to females in all childhood age groups. For children less than one year of age, two-thirds of injury deaths are due to suffocation, while drowning is the leading cause of injury death for those one to four years of age.<sup>14</sup>

Two-thirds of injury related death in children under one year old are due to suffocation.

In 2009 CFNFRB review findings were consistent with national trends noted by the CDC with respect to accident deaths. Accidental manner of death comprised 23% (42) of the total 184 deaths reviewed by the CFNFRB in 2009.

Asphyxia was the leading cause of accidental deaths, with 45% (19), making up nearly half of all accidental deaths reviewed, as detailed below in Figure 8-1. Drowning was the second leading cause of accidental death, with 34% (14), as detailed in the drowning section.

In 10% (4) of the accidental manners reviewed, the deaths were attributed to accidental overdose. These 4 accidental overdose deaths occurred in adolescents, ages 16 and 17, all with substance abuse histories. Three of the cases included poly-substance use, such as opiates, cocaine, PCP, and marijuana. The fourth youth combined alcohol and Lithium, leading to an accidental overdose, less than three months after discharge from an inpatient psychiatric and substance abuse hospital.

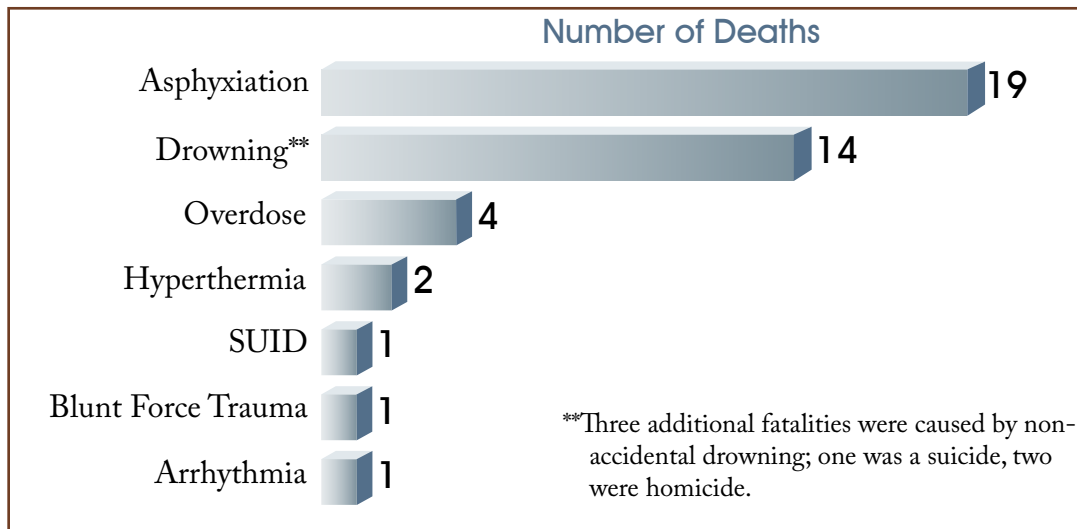
In 5% (2) of the deaths with accidental manners, the cause of death was attributed to hyperthermia. One involved a three-year-old child who was left in the family car for approximately two hours, exposed to high ambient temperature. The second involved a five month old infant who was placed in a bathroom with shower steam, in an attempt to alleviate congestion. The parent fell asleep, leaving the infant in the steam for approximately four hours.

The remaining 6% of deaths with accidental manner were comprised of 2% (1) caused by Sudden Unexpected Infant Death (SUID), classified as an accident in manner due to a parent overlay while co-sleeping with the infant, 2% (1) caused by multiple blunt force trauma, when a child, age six, unknowingly drove the family's ATV (all terrain vehicle) and crashed into oncoming traffic, and 2% (1) caused by cardiac arrhythmia, when a 17-year-old youth was found unresponsive after inhaling aerosol vapors.

<sup>14</sup><http://www.cdc.gov/SafeChildhoodInjuryReport/bSummary.html>

Figure 8-1

## Accidental Deaths by Cause

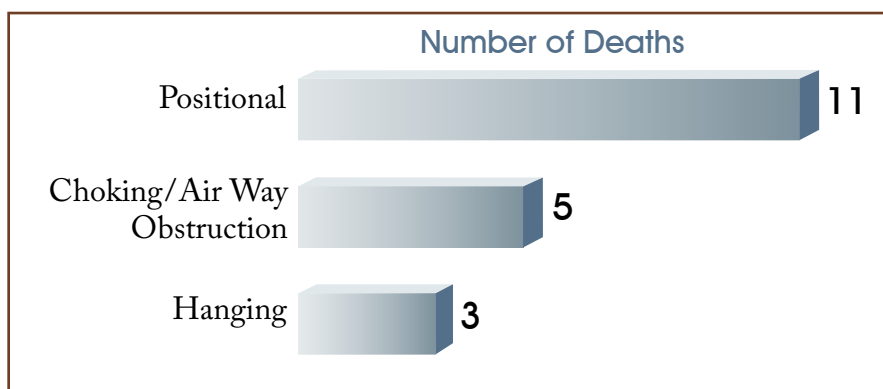


## Types of Accidental Asphyxia

Fifty eight percent (11) of accidental asphyxia deaths reviewed were due to positional asphyxia, involving suffocation or overlay of an infant who was co-sleeping with a parent, caregiver, or sibling. This was followed by 26% (5), due to choking or airway obstruction, including one child with food found in the airway during autopsy, one child who choked on a deflated balloon, one child who choked on the cap of an insulin syringe, one child whose nose and mouth were obstructed during breast feeding, and one child, age 13 with severe cerebral palsy, who died of asphyxia when a shelf fell on him, causing neck, and chest compression. Sixteen percent (3) asphyxia deaths were due to accidental hanging, including a one year old child caught in a mini-blind cord, an eight year old child who accidentally hung himself from a banister while playing, and one child, age five, who suspended a draped sheet from overhead pipes to make a swing, accidentally hanging herself. There was one additional infant asphyxia death reviewed not included in this data set as the cause was attributed to homicide, not accident.

Figure 8-2

## Types of Accidental Asphyxia Deaths



## Drowning

In 2005, there were 3,582 unintentional drowning deaths in the United States, averaging ten deaths per day. More than one in four fatal drowning victims are children 14 and younger.<sup>15</sup> For every child who dies from drowning, another four received emergency department care for nonfatal submersion injuries.

In 2005, there were 3,582 unintentional drowning deaths in the United States, averaging ten deaths per day.

Drowning, the "process of experiencing respiratory impairment from submersion or immersion in liquid," is the second leading cause of unintentional death among children ages one to four years and children 10 to 14 years. For infants less than one year, drowning is the third leading cause of unintentional death.<sup>16</sup>

The CFNFRB reviewed the cases of 17 drowning and drowning related fatalities which occurred in 2008.<sup>17</sup> Most of the drowning fatalities (82.4%) in 2008 were certified by a medical examiner as accidental deaths; however, two were certified homicides and one was certified a suicide. In one homicide, a teenaged mother gave birth in a public restroom and stuffed the infant's body into the holding tank of a toilet. In the second homicide incident, a mentally ill mother drowned her child in a bathtub. In the suicide, a 14 year old female, who was a witness to domestic violence and experienced recent tragic deaths of her friends, was found at the bottom of her community pool after she had expressed suicidal ideation to a friend.

### WHERE DO CHILDREN DROWN?

The majority of drowning deaths in New Jersey occurred in pools regardless of the age of the child. There were an equal number of children (three) at either end of the age range who drowned in either a bathtub (infants) or in open bodies of water (adolescents). According to Safe Kids Worldwide, the majority of infants (less than one year old) drown in bathtubs, buckets, or toilets.<sup>18</sup> Children aged 1-4 are most likely to drown in hot tubs, spas, and swimming pools and children aged 5-14 most often drown in swimming pools and open water such as rivers, lakes, dams, and canals.<sup>19</sup> As Figure 8-3 on the next page illustrates, the CFNFRB's data was similar to national data in that three of the four infants (75%) drowned in bathtubs, 83.3 % children between the ages of one and four drowned in pools, and all of the children between the ages of five and 17 drowned in a pool or open water.

<sup>15</sup> <http://www.cdc.gov/HomeandRecreationalSafety/Water-Safety/waterinjuries-factsheet.htm>.

<sup>16</sup> World Health Organization, Department of Injuries and Violence Prevention, Facts about Injuries: Drowning, Retrieved from [http://www.who.int/violence\\_injury\\_prevention/publications/other\\_injury/en/drowning\\_factsheet.pdf](http://www.who.int/violence_injury_prevention/publications/other_injury/en/drowning_factsheet.pdf)

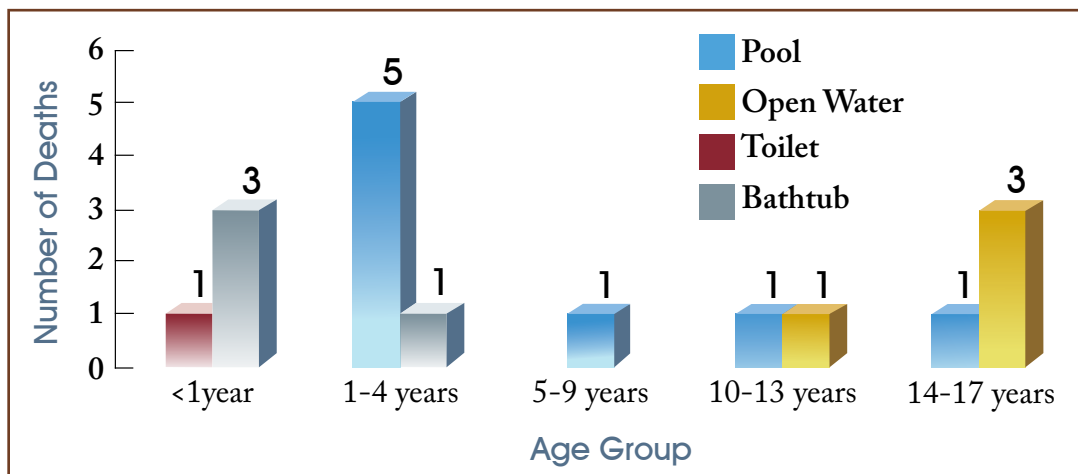
<sup>17</sup> There were two drowning related fatalities where a child expired as a result of withdrawal of life support after a near drowning incident.

<sup>18</sup> Safe Kids Worldwide (SKW). Drowning and Water-Related Injuries, Washington (DC): SKW, 2007.

<sup>19</sup> National Drowning Statistics, Infant Swimming Resource, Retrieved from [www.infantswim.com](http://www.infantswim.com)

Figure 8-3

## Drowning Fatalities by Age Group and Incident Location (2008)



When comparing statistics over the last three years, the CFNFRB's figures illustrate that more fatalities occur as a result of drowning in a residential or community pool than any other location. There were 11 drowning deaths in pools located in family backyards and five drowning deaths in community pools from 2006 to 2008. The CFNFRB noted that in those 11 residential drowning deaths, the children drowned in either their own pool or at the home of a friend or relative. Children did not wander off and accidentally fall into a neighbor's pool as is often speculated. In six (55%) drowning incidents from 2006-2008, there was no fencing around the perimeter of the pools. In four drowning deaths the investigators responding to the death scene did not document what, if any, barriers existed to prevent access to the pool. There was one incident where there was a fence around the perimeter of the pool but the fence was left open, allowing easy access for the child who drowned.

Five of the 11 pool drowning victims were last seen playing in the yard, three were thought to be inside the home but left the home and accessed the yard and pool, two were last seen in the pool, and no one other than the teenager who drowned was home during one incident. This information indicates that if there were a locked gate or fence around the pool itself, eight of the 11 children may not have drowned. Two conclusions can be drawn from the above

### Infant and Toddler Drowning Risk Factors

- Children near water who are not adequately supervised
- No barriers prohibiting access to water within the child's reach
- Open containers of water within a child's reach
- Exposed ladders or diving boards make it easier for children to enter pools

### Infant and Toddler Drowning Prevention

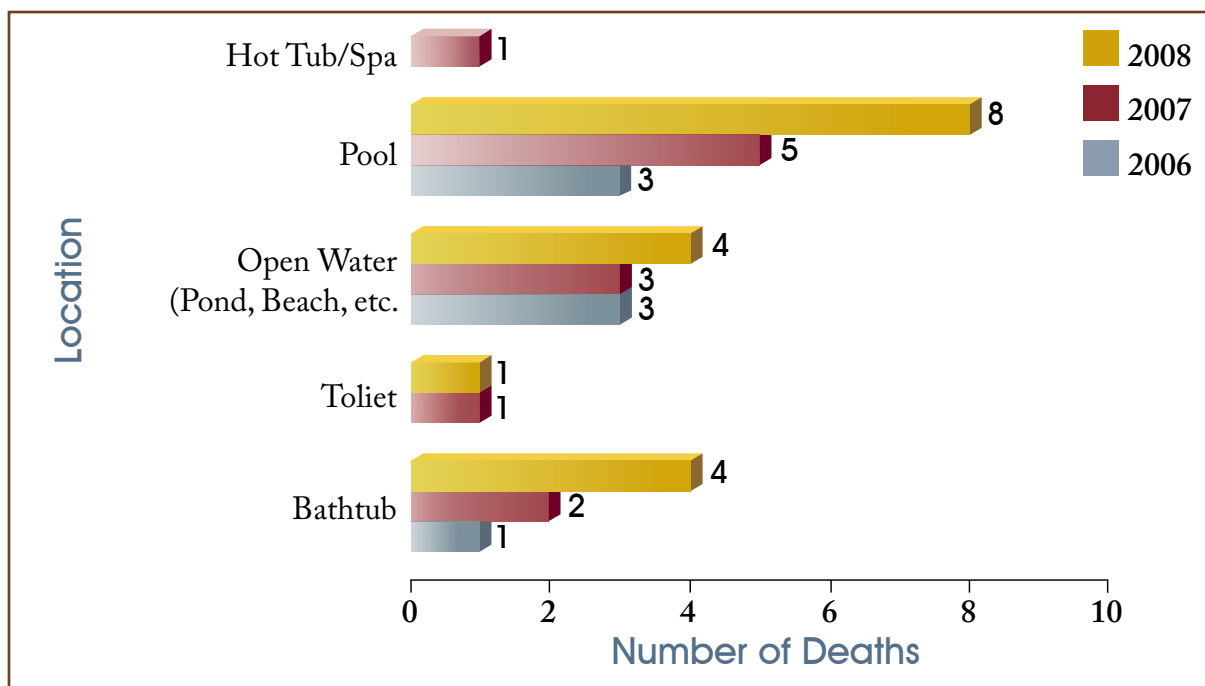
- Caregivers who are vigilant at all times children are near any depth of water
- Store away ladders and cover the pool or hot tub when not in use
- Self-latching gate around the pool perimeter
- Pool alarms
- Learn CPR skills

information; first, it especially important for municipal ordinances to mandate fencing around the perimeter of a pool and not just around the yard and second, it is important that the side of the house not be used as the fourth side of the perimeter around a pool. This information also reaffirms the importance of water safety and that parents and caregivers must be vigilant in their supervision of children while in or near water, even when there are other adults around and/or a lifeguard on duty. See Figure 8-4.

### Adolescent Drowning Risk Factors

- Inability to swim
- Adolescents involved in risky behavior while swimming in open water, including but not limited to the use of drugs and alcohol
- Swimming in areas of water which have signs prohibiting the act

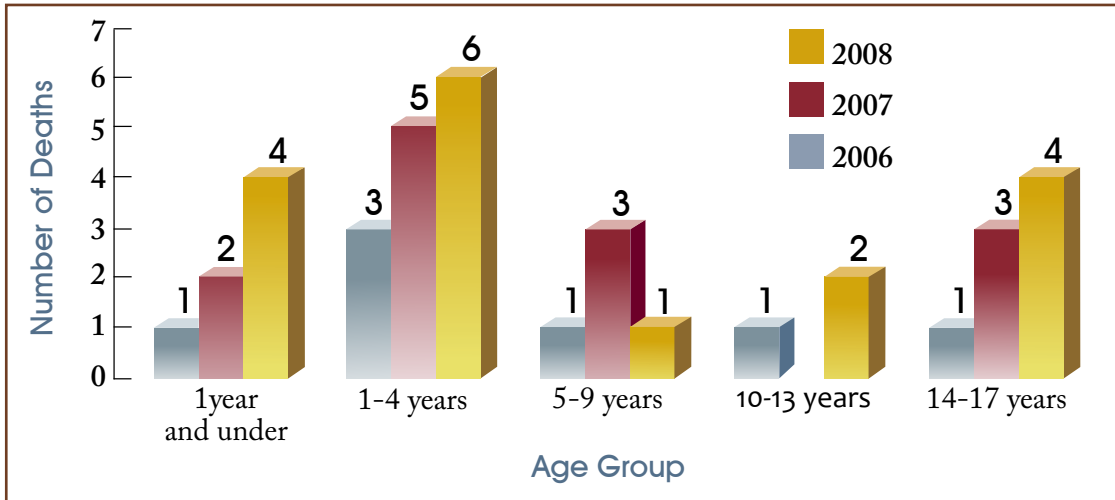
**Figure 8-4** Drowning Fatalities by Location (2006-2008)



### Are there Trends in Drowning Fatalities?

The CFNFRB analyzed data from 2006 through 2008 to determine whether New Jersey had trends similar to national studies. On average, it appears that New Jersey's statistics are comparable to national statistics regarding most trends, including age, race/ethnicity, and gender.

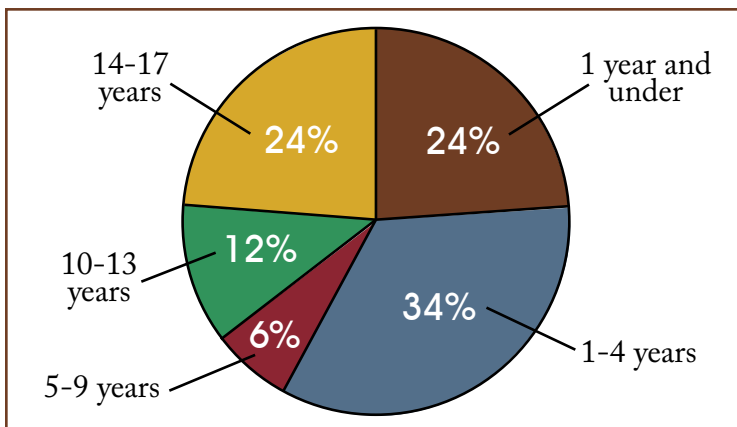
Figure 8-5 Drowning Fatalities



As shown in Figure 8-5, New Jersey has repeatedly experienced higher numbers of fatalities in children ages four and under. In 2008, the number of drowning victims age four and younger made up more than half of the total drowning fatalities (58.8%).

Below is a table showing drowning fatalities in 2008 (Figure 8-6). The CFNFRB found that there were spikes in children who drowned between the ages of 0-4 and 14-17. In reviews of 2008 drowning fatalities, 82% of the victims were between 0-4 and 14-17 years old.<sup>20</sup> This is consistent with the CDC's WISQARS data for 2007, which shows that 80% of drowning victims in the United States were children between 0-5 years old and 14-17 years old. The percentage of children who died in each of the age groups; < 1 year old, 1-4 year old, and 14-17 year old outnumbered the 5-9 year old and 10-13 year old age groups combined.

Figure 8-6 NJ Drowning Fatalities (2008)



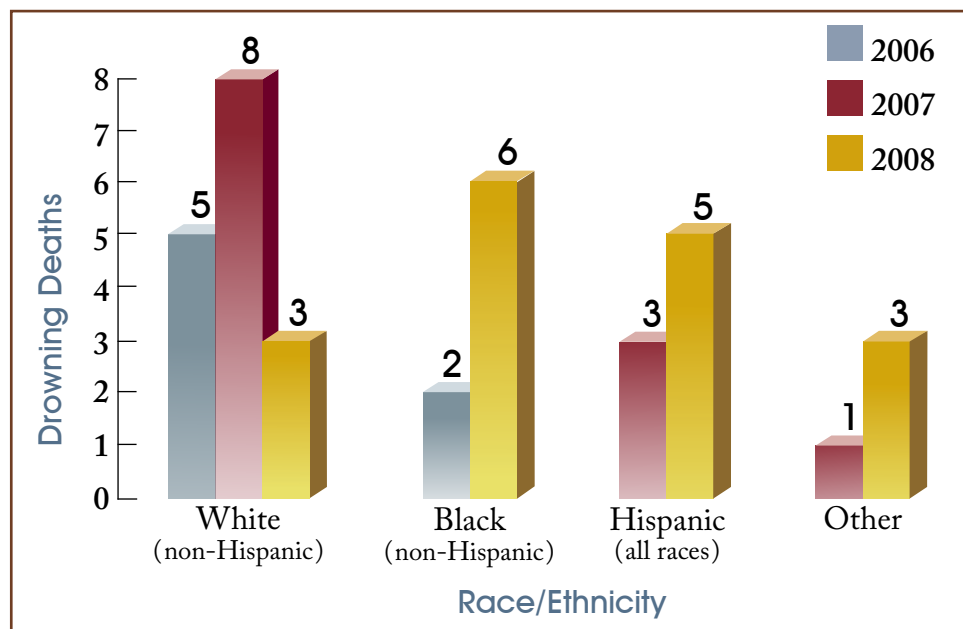
<sup>20</sup>Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010) [cited 2010 June 2]. Available from: URL: <http://www.cdc.gov/injury/wisqars>

## Race/Ethnicity

Figure 8-7 below illustrates drowning fatalities by race/ethnic categories. According to these numbers, White (non-Hispanic) children make up almost half the number of total drowning fatalities since 2006. However, New Jersey's statistics are lower than the national statistics which report that White (non-Hispanic) children accounted for 73% of childhood drowning deaths.<sup>21</sup>

Figure 8-7

Drowning Deaths by Race/Ethnicity



According to Safe Kids Worldwide, Black (non-Hispanic) male children ages 5 to 14 have a fatal drowning rate three times that of their white counterparts.<sup>22</sup> It is reported that ethnic minority groups generally have higher drowning rates, possibly due to differences in opportunities to learn to swim.<sup>23</sup> However, the CFNFRB has not seen a significant trend in ethnicity/race or data to corroborate national studies. In fact, it was only in 2008 that the fatality rate of Black (non-Hispanic) children was significantly higher than that of White (non-Hispanic) children. The fatality rates per 100,000 children in 2008 were as follows; .27 White (non-Hispanic), 1.98 Black (non-Hispanic), 1.18 Hispanic (all races), and 1.89 Asian. Overall, the total number of White (non-Hispanic) drowning fatalities from 2006 to 2008 is double that of Black (non-Hispanic) fatalities and Hispanic (all races) fatalities; which is represented by Figure 8-7. However, when the child population of each race/ethnicity is factored in, the statistics appear more congruent with national statistics which state that Black (non-Hispanic) children have drowning rates 50 to 70% higher than white children do.<sup>24</sup> The same study also reports

<sup>21</sup>Cody B.E., Quraishi A.Y., Dastur M.C., Mickalide A.D. Clear Danger: A National Study of Childhood Drowning and Related Attitudes and Behaviors. Washington (DC): National SAFE KIDS Campaign, April 2004.

<sup>22</sup>Department of Health and Senior Services, Centers for Disease Control and Prevention. Water-Related Injuries: Fact Sheet. Retrieved from [www.cdc.gov/HomeandRecreationalSafety/Water-Safety/waterinjuries-factsheet.htm](http://www.cdc.gov/HomeandRecreationalSafety/Water-Safety/waterinjuries-factsheet.htm)

<sup>23</sup>World Health Organization, Department of Injuries and Violence Prevention, Facts about Injuries: Drowning, Retrieved from [www.who.int/violence\\_injury\\_prevention/publications/other\\_injury/en/drowning\\_factsheet.pdf](http://www.who.int/violence_injury_prevention/publications/other_injury/en/drowning_factsheet.pdf)

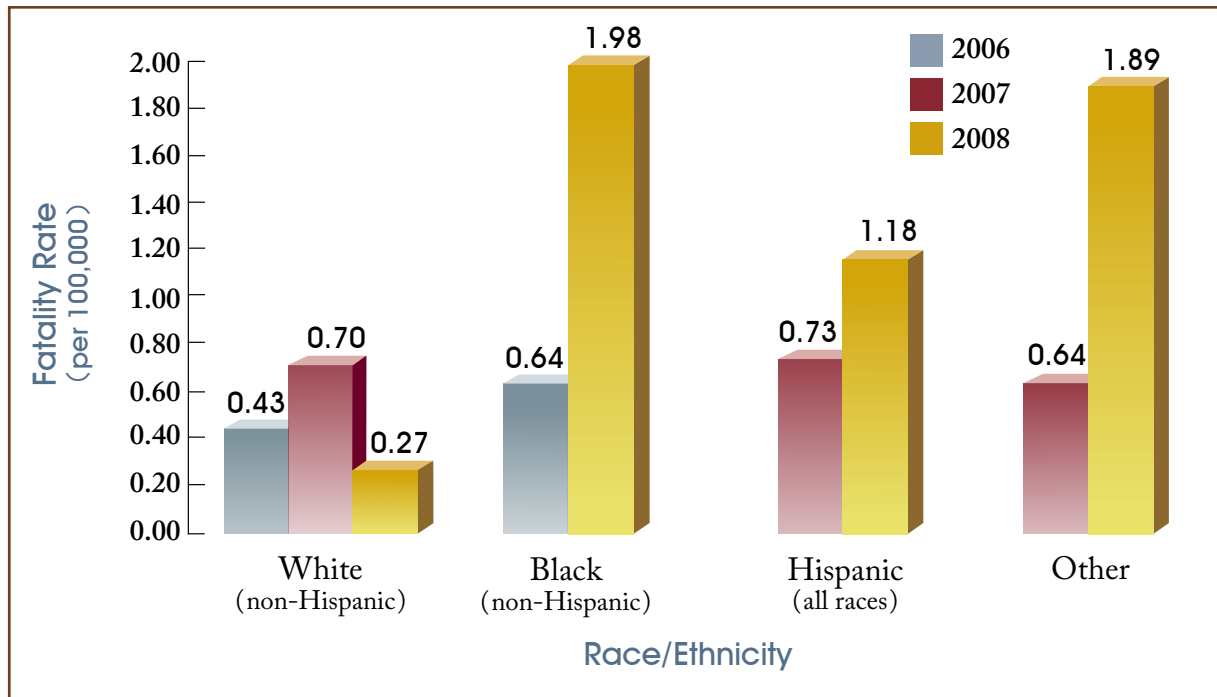
<sup>24</sup>Cody BE, Quraishi AY, Dastur MC, Mickalide AD. Clear Danger: A National Study of Childhood Drowning and Related Attitudes and Behaviors. Washington (DC): National SAFE KIDS Campaign, April 2004.



Hispanic (all races) children have lower drowning rates than non-Hispanics, accounting for only 15% of U.S. childhood drowning. However, this is inconsistent with CFNFRB data which shows that Hispanic (all races) children accounted for 29% (5) of fatalities in 2008 and the fatality rate was higher than that of White (non-Hispanic) children. Figure 8-8 shows the CFNFRB's fatality rate data by race/ethnicity from 2006 through 2008.<sup>25</sup> According to the Centers for Disease Control and Prevention, factors such as the physical environment (e.g., access to swimming pools) and a combination of social and cultural issues (e.g., valuing swimming skills and choosing recreational water-related activities) may contribute to the racial differences in drowning rates.

Figure 8-8

NJ Drowning Fatality Rate by Race/Ethnicity



## Gender

Overall, the rate of male drowning death is more than twice that of females.<sup>26</sup>

The CFNFRB found that in 2006 and 2007, there were more male drowning deaths than female, but in 2008, there were more female drowning deaths than male. See Figure 8-9. With data from the last three years taken as a whole, there were twice as many male fatalities than female; consistent with the World Health Organization statistics. Studies suggest males have higher drowning rates than females due to increased exposure to water and riskier behavior.<sup>27</sup>

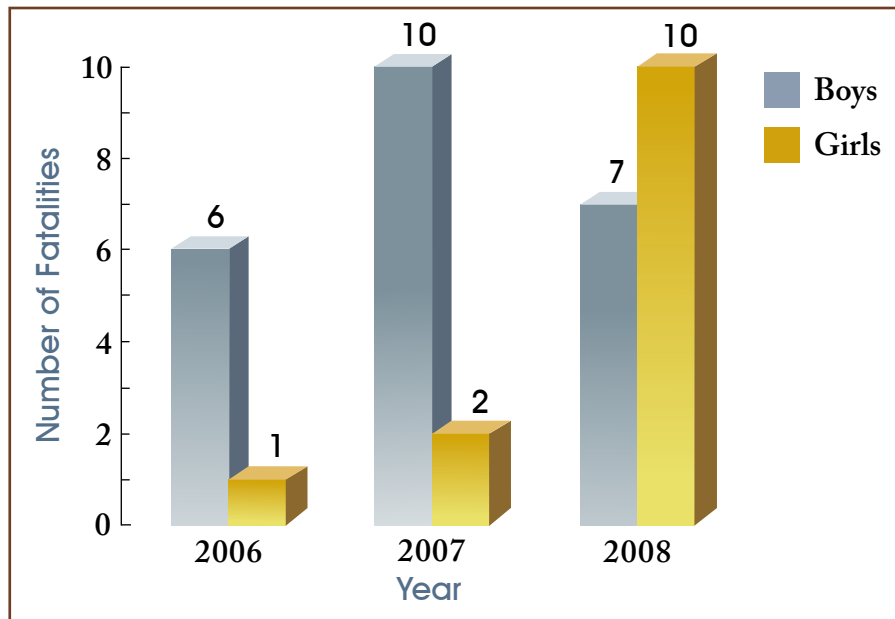
<sup>25</sup> Fatality rates were calculated using population numbers from The Annie E. Casey Foundation, KIDSCOUNT Data Center, [datacenter.kidscount.org](http://datacenter.kidscount.org)

<sup>26</sup> World Health Organization, Department of Injuries and Violence Prevention, Facts about Injuries: Drowning, Retrieved from [www.who.int/violence\\_injury\\_prevention/publications/other\\_injury/en/drowning\\_factsheet.pdf](http://www.who.int/violence_injury_prevention/publications/other_injury/en/drowning_factsheet.pdf)

<sup>27</sup> World Health Organization, Department of Injuries and Violence Prevention, Facts about Injuries: Drowning, Retrieved from [www.who.int/violence\\_injury\\_prevention/publications/other\\_injury/en/drowning\\_factsheet.pdf](http://www.who.int/violence_injury_prevention/publications/other_injury/en/drowning_factsheet.pdf)

Figure 8-9

## Drownings by Gender



### WHY DO CHILDREN DROWN?

There are five "truths" about children who drown, as reported by Safe Kids USA.

The factors, which are all avoidable, are

- ① Weak or no supervision
- ② No barriers (covers on hot tubs, gates around pools containers of water within a child's reach)
- ③ Weak or no CPR skills
- ④ Weak or no swimming ability
- ⑤ Lack of life jacket use

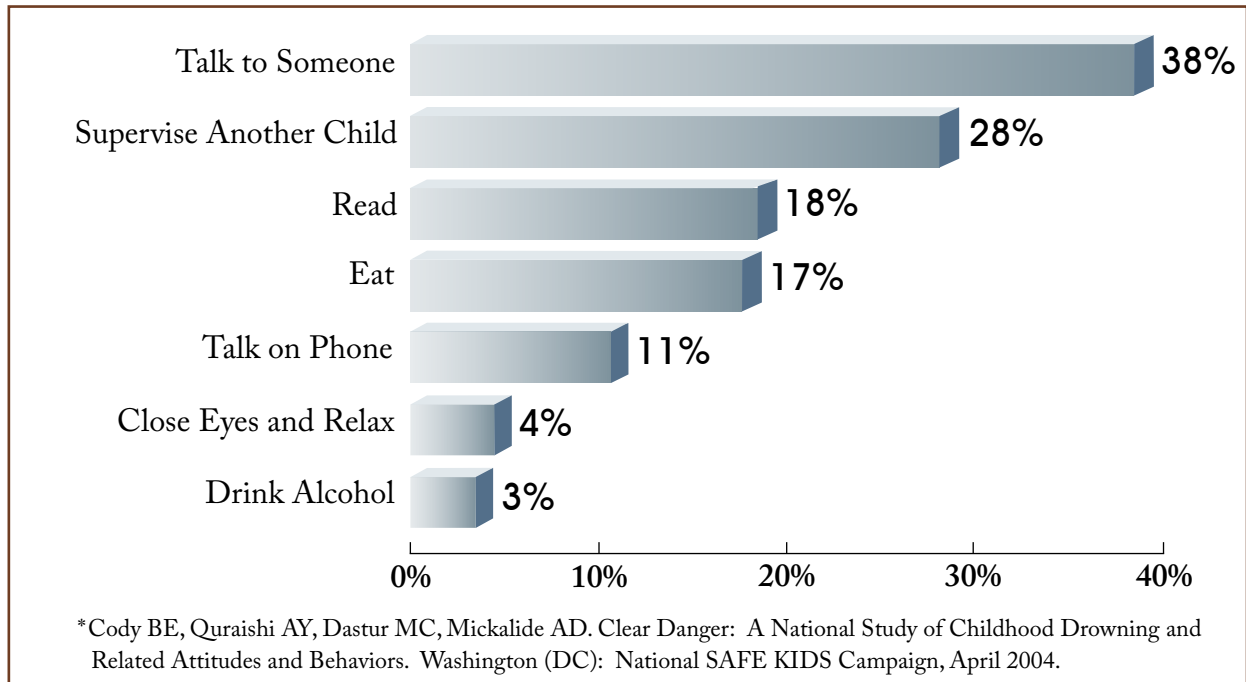
### Supervision

Supervision is a key element in prevention of child drowning fatalities. Many parents and caregivers do not find error in passively supervising their children in or near water while talking on the phone, reading a book, or engaging in other distracting activities. According to a national study of drowning-related incidents involving children, a parent or caregiver claimed to be supervising the child in nearly nine out of 10 child drowning-related deaths.<sup>28</sup> Figure 8-10 shows the percent of caregivers who admitted to partaking in each activity while supervising their children swimming; some caregivers are actually engaged in more than one distracting behavior.

<sup>28</sup> Safe Kids Worldwide (SKW). Drowning and Water-Related Injuries, Washington (DC): SKW, 2007.

Figure 8-10

## Self-Reported Activities of Parents while Supervising their Child Swimming\*



Unfortunately, the reality is that children can drown in a matter of seconds and often drown quickly and without a sound. Childhood drowning and near drowning "typically occur when a child is left unattended or during a brief lapse in supervision."<sup>29</sup>

The CFNFRB reviewed 17 fatalities in 2008 and found that six children did not necessarily require supervision due to being over age 12. For the purposes of this report, the CFNFRB will consider a child supervised if, at some point while the child was in or around water, an adult was in the presence of the child. Nine children were supervised for varying periods of time while two children required but did not have any supervision. Of the two children who had no supervision, a 22 month old child drowned in the bathtub while the parents were sleeping and a 25 month old drowned in a backyard pool while the father was inside the home on the computer. As mentioned above, many children who drown had some type of supervision by or were in the presence of a caregiver. However, many caregivers supervising children in or near water engage in distracting activities. The CFNFRB noted three caregivers were watching or tending to other children, two left the swimming area for a brief time, one child's parents were in the backyard with the child but socializing during a dinner party, and one was talking on the telephone. The other two children were intentionally drowned by their parent.

**Two minutes following submersion, a child will lose consciousness. Irreversible brain damage occurs after 4-6 minutes.**

*National SAFE KIDS Campaign (NSKC) Drowning Factsheet. Washington (DC): NSKC, 2004]]*

<sup>29</sup> National SAFE KIDS Campaign (NSKC) Drowning Factsheet. Washington (DC): NSKC, 2004

## Safety Precautions

There are a number of safety precautions that pool owners can take to minimize drowning incidents. These include, but are not limited to, fencing around the pool, self-closing/self-latching gates, alarms on doors leading directly to pools, pool alarms, and lifeguards. The CFNFRB looked at the number of deaths occurring in residential pools with gates or other safety precautions. In 2008, there were five children who drowned in residential (home) pools and three children who drowned in community pools. Of the five children who drowned in residential pools, only one pool had fencing and locking gates installed. The community pools had gates and fencing but two died in pools where there were no lifeguards and one died in a pool with lifeguards; one child was swimming with family after hours, the other climbed over a locked fence and committed suicide, and the third child died in a community's natural pool with lifeguards present.

## Swimming Ability

Swimming ability is an important factor in drowning incidents. Victims did not know how to swim in 88.2% (15 of 17) of the drowning incidents reviewed in 2008. Some victims were unable to swim due to age and some children appear to have never learned. The CFNFRB analyzed the cases of six children who were older than 12 years old and found that only two could swim. One could speculate that some of these children may have survived, had they known how to swim. Regrettably, a child is not necessarily safe from becoming a victim of drowning just because he or she has the ability to swim. There are other factors which may contribute to the drowning death of a child. In 2008, the CFNFRB reviewed the case of a child who drowned after symptoms of what appeared to be a possible seizure and another child, who drowned after smoking marijuana laced with PCP and attempting to swim in a pond where "no swimming" signs were posted. Although there is no fail-safe way to ensure that children do not drown, the importance of knowing how to swim cannot be minimized, especially if children are exposed to community and residential pools, beaches, or parks with natural bodies of water.

### SUMMARY

- Children ages 1-17 drown most often in a pool or open water (i.e. lakes, beaches, rivers, dams, canals)
- A lapse in supervision resulted in more than half of the drowning fatalities reviewed.

## Natural Deaths (DYFS Involved Families)

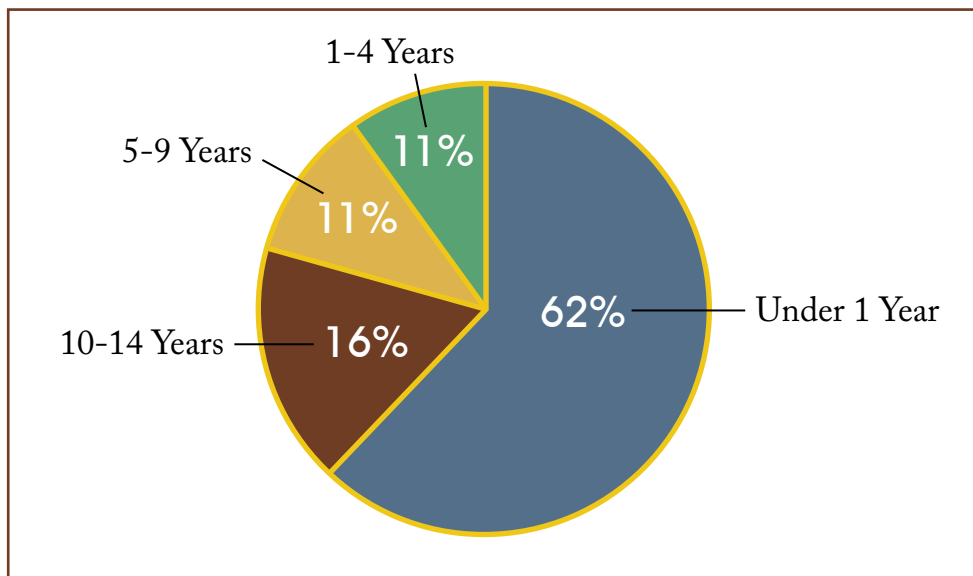
Pursuant to N.J.S.A. 9:6-8.90, the CFNFRB may review the fatality of any child whose family had DYFS involvement within 12 months immediately preceding death; including those whose cause of death was certified natural. The CFNFRB reviewed a total of 67 fatalities due to natural causes in 2008. (The CFNFRB's statistics regarding natural deaths are not representative of all natural deaths occurring in New Jersey due to case selection criteria.) 70.15% (47) of these natural fatalities were certified as SIDS/SUID/SUDC deaths and were discussed in the SIDS/SUID/SUDC section of this report. This section will focus on the 18 children whose families had DYFS involvement and died of congenital or other natural conditions. The CFNFRB reviewed 9 (50%) deaths attributed to congenital conditions, 8 (44.4%) deaths attributed to other natural conditions, and 1 (5.6%) death which appeared to be due to a combination of congenital and other natural causes.

### Age

According to the CDC, deaths due to congenital anomalies are the leading cause of death in children less than one year old, the second leading cause of death in children 1-4 years old, and the third leading cause of death in 5-9 year olds. The children who died in 2008 due to natural causes and met review criteria ranged in age from 11 days old to 13.5 years old. As with many other fatalities, the number is greatest in the children less than one year old (62%). See Figure 9-1 below.

Figure 9-1

Age of Natural Fatalities Open with DYFS (2008)

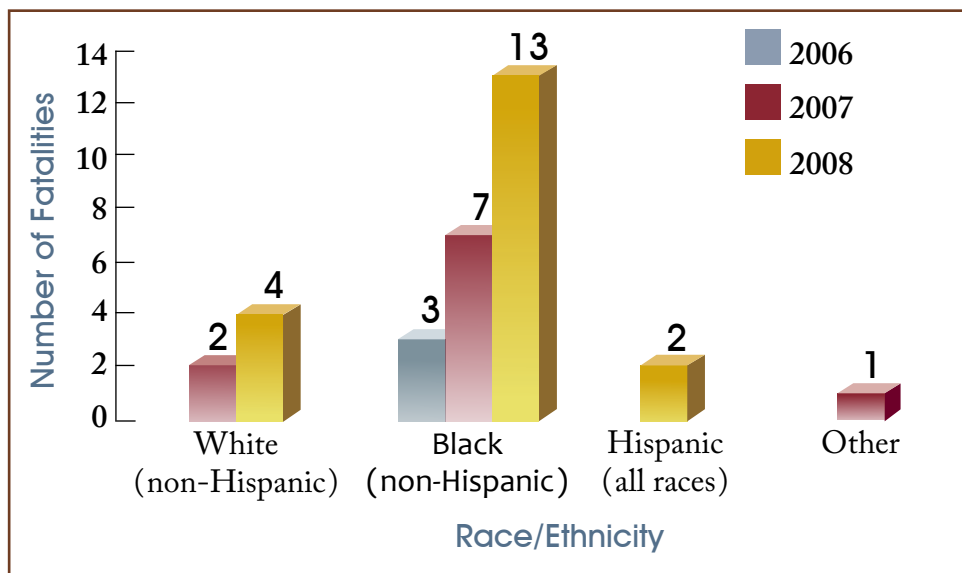


## Race/Ethnicity

According to DCF demographic information from 2006, the proportion of Black (non-Hispanic) children comprise approximately a third (36%) of children served by DYFS. White (non-Hispanic) children make up another third (34%) while race information is missing or undetermined for 28%. The remaining categories combined; multiple races, Asian, American Indian or Alaska Native, and Native Hawaiian/Other Pacific Islander, make up approximately 2% of the population served by DYFS. The Web site also reports that of the total population of children served by DYFS, 63% are non-Hispanic, 15% are Hispanic (all races), and 22% are undetermined or missing the information.<sup>30</sup> The demographic information on the DCF website does not suggest the proportions of Black (non-Hispanic) child fatalities seen by the CFNFRB. Data over three years (2006-2008) illustrates that more Black (non-Hispanic) children with DYFS involvement are dying as a result of natural causes than any other race or ethnic group. See Figure 9-2 below.

Figure 9-2

### Natural Fatalities of Children Under DYFS Supervision by Race/Ethnicity



## Gender

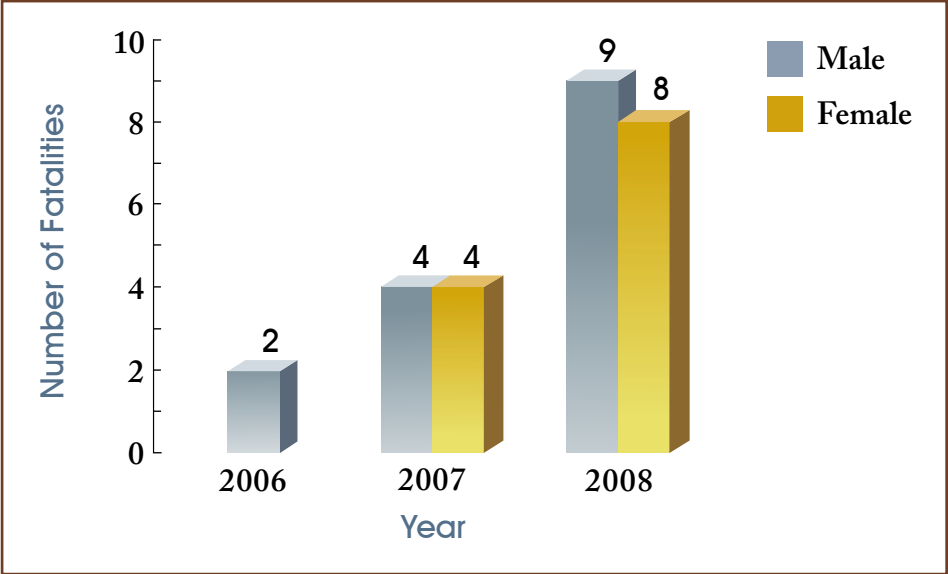
There has not been a significant trend noted in the gender of children who die in New Jersey of natural causes and have DYFS involvement. The statistics regarding children who died in 2007 and 2008 for boys and girls are almost identical. As of June 2009, demographic information from DCF shows that the number of boys and girls served by DYFS is fairly equal (51% boys, 48% girls, 1% unknown).<sup>31</sup> National statistics from 2006, however, show that males represent more than double the number of

<sup>30</sup><http://www.state.nj.us/dcf/home/childdata/dyfsdemo/index.html>

<sup>31</sup><http://www.state.nj.us/dcf/home/childdata/dyfsdemo/index.html>

fatalities than female fatalities (62 male versus 29 female).<sup>32</sup> See Figure 9-3 below. The discrepancy in statistics can be attributed to the fact that the CFNFRB only reviews natural deaths where families had DYFS involvement in the past 12 months. National statistics include children of families with no child protective service involvement, premature infants, intrauterine fetal demise, among other conditions, that do not fit criteria for CFNFRB review.

**Figure 9-3** | NJ Natural Fatalities by Gender



### Where In NJ Did These Natural Deaths Occur?

The highest incidence of death due to natural causes and who had DYFS involvement was in Camden County (five); the next highest incidence was in Essex County (four). Mercer and Passaic County each had two fatalities and Atlantic, Monmouth, Middlesex, and Morris each had one fatality of a child with previous DYFS involvement expiring due to natural causes.

**SUMMARY**

- It is vital to reinforce the importance of obtaining prenatal, follow up, and routine medical care for their children, especially those under one, because the majority of fatalities certified natural deaths are of children less than one year old.
- The Black (non-Hispanic) population has the highest incidence of natural fatalities. However, prevention and intervention must be targeted towards all cultural and ethnic groups.

<sup>32</sup>Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-Based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005) {Cited 2010, February 24}. Available from [www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars)

# Undetermined Deaths

An undetermined cause or manner of death is the result of insufficient or conflicting information from the death scene investigation, the clinical history, or the autopsy findings.

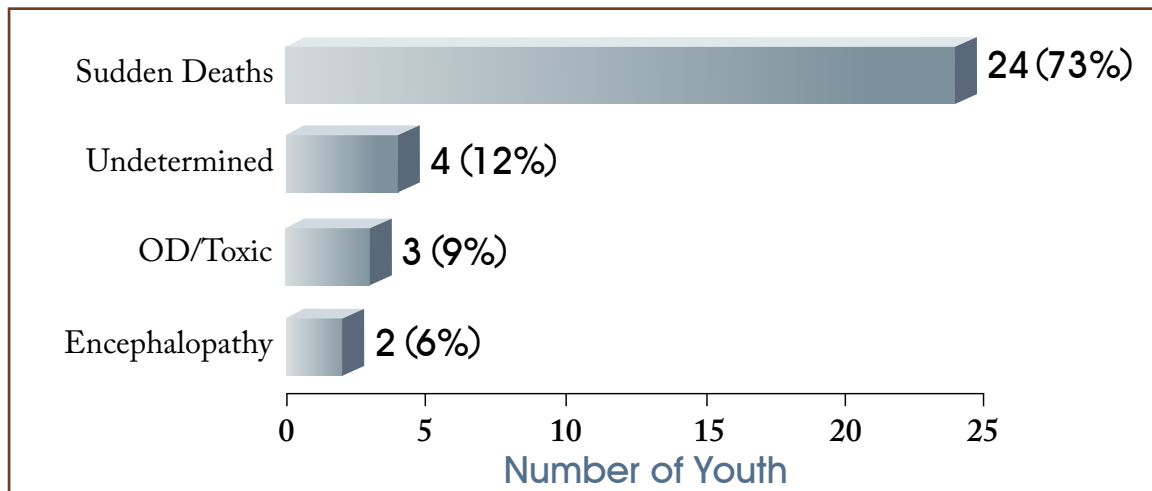
Several factors can affect the information collected that is used in making the cause and manner of death determinations. Incomplete death scene investigations, inconclusive or conflicting forensic information, or the absence of a full autopsy, can all contribute to an undetermined manner or cause of death.

- Death scene investigations can be limited by witnesses too distraught to fully participate in the investigation, or others who may provide selective or conflicting answers.
- Sometimes an undetermined manner of death reflects forensic information which could not clearly identify if actions leading to the death were intentional or accidental. For example, when a youth with a history of using drugs dies due to overdose, without clear forensic evidence it may be difficult to determine if the overdose was intentional (suicide) or an accident, therefore resulting in an undetermined manner.
- Performing a complete autopsy can be prevented by family member's objections, or because of religious or cultural conflicts, as was the case in six of the fatalities reviewed in 2009 (four objections by family for unknown reasons, and two objections due to religious reasons). In such cases the medical examiner can use external examinations, toxicology reports, and death scene investigation information to determine the cause and manner of death. In some instances medical examiners can use post mortem MRI's and body scans as part of a system of "virtual autopsy" as an alternative to more invasive procedures.

Per N.J.S.A. 9:6-8.90, all deaths with an undetermined cause or manner are reviewed by the CFNFRB.

The CFNFRB reviewed a total of 33 deaths with an undetermined manner. These included causes of death such as, sudden infant death, encephalopathy related to hanging, drug and medication overdose or toxicity, and undetermined cause, sometimes with contributing factors, such as the overlay of an infant while co-sleeping. See Figure 10-1 on the next page.





In 73% (24) of the deaths with undetermined manners, the cause of death was classified as Sudden Infant Death Syndrome, Sudden Unexpected Infant Death, or Sudden Unexpected Death of a Child, when after investigation, autopsy, and clinical history review; all other medical problems or contributory causes were ruled out.

### Undetermined Cause and Manner

In 12% (four) of the fatalities reviewed, both the cause and manner were classified as undetermined, with inconclusive forensic evidence that could not clearly identify a cause or manner of death. These included:

- An infant age two months, found unresponsive in the parents' bed after co-sleeping with the parent the previous night, with no signs of trauma or injury, and negative toxicology results during autopsy.
- An infant, age five months, with vomiting and diarrhea after feeding, then later found unresponsive, with no signs of trauma or injury. Toxicology and laboratory reports found traces of ethanol and Oxycodone in the infants system, and bacteria in the bottles (*Enterococcus Faecium* and *Klebsiella Pneumoniae*).
- A newborn infant, delivered at home, then later taken to the hospital by the mother who had lost consciousness after the birth. The infant was found unresponsive, with no signs of injury or trauma.
- A two year old child, found unresponsive, with elevated temperature of 101 degrees, no signs of injury or trauma, and a negative toxicology report during autopsy.

In 9% (three) of the deaths with undetermined manner, the cause of death was due to drug or medication overdose or toxicity. These included:

- A 16 year old youth with history of poly-substance abuse, whose cause of death was noted as cocaine and heroin intoxication. The intent of the youths overdose could not be established; therefore manners of suicide or accident could not be identified, leading to an undetermined manner.
- A three year old child found unresponsive, with no signs of injury or trauma. The autopsy toxicology report noted Oxycodone in the child's system, in an amount equivalent to one tablet. The mother confirmed using a friend's medication for tooth pain, and had misplaced half a pill. Intent of the child's contact with the medication could not be established by the information available, leading to an undetermined manner of death determination.
- An 11 month old infant found unresponsive with no signs of injury or trauma. The autopsy toxicology report noted morphine and codeine in the infants system. Both parents had history of drug abuse. The intent of how the infant came into contact with the substances could not be established, so a manner of accident or homicide could not be identified, leading to the manner being declared as undetermined.

In 6% (two) of the deaths with undetermined manner, the cause of death was due to encephalopathy, including:

- A three month old infant found unresponsive while co-sleeping with a parent. Although resuscitation was initially successful, the infant was declared "brain dead" days later in the hospital.
- A 16 year old youth who made comments to another teen about committing suicide, while tying a belt around his neck and a banister, seemingly out of jest, or horseplay. The teen was found hanging, and unresponsive. The youth had no history of mental illness, suicidal ideations, or substance abuse. The intent of the youth's actions could not be established with respect to determining if the manner was suicide or an accident, therefore the manner was declared undetermined.

## Homicide (perpetrated by a non-caregiver)

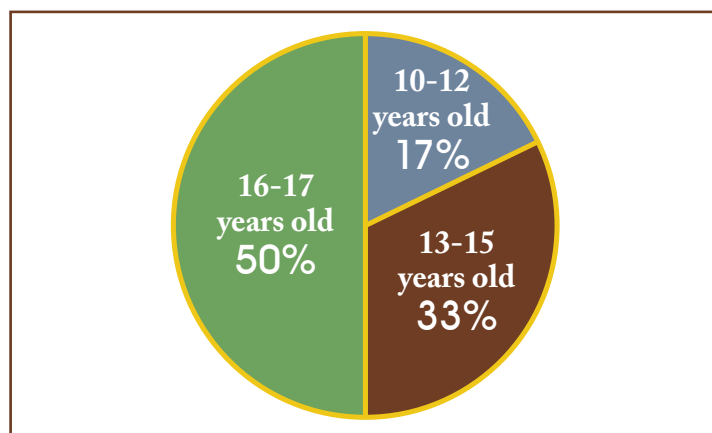
In 2008, the Board's data revealed that 67% of juvenile homicides by a non-caregiver were committed using a firearm. Involvement of a firearm in a fatality depended greatly on the age of the victim. Nationally, 17% of murdered juveniles younger than age 13 were killed with a firearm, compared to 80% of murdered juveniles age 13 or older.<sup>33</sup>

This section will discuss reviews of homicide deaths which were not the result of child abuse or neglect. These homicides were of children, typically adolescents, whose families were under DYFS supervision at the time they were killed or within 12 months preceding the homicide, by persons other than their caregivers. The CFNFRB reviewed the cases of six youth who were killed by a non-caregiver. Four of the six youths died as a result of gun violence, one was strangled to death by a relative not in the role of a caregiver, and the other expired as a result of smoke inhalation due to arson by an unknown suspect.

### Age

The majority of non-child abuse homicides occurred with adolescents age 16-17 years old. As Figure 11-1 below demonstrates, 50% of non-child abuse homicides represented this age group. Among these fatalities, all of the children in the 13-15 year old age group (two) and two of the three children in the 16-17 year old age group were killed as a result of gun violence. This is a slight improvement from statistics in 2006 and 2007, which show that the numbers were 75% and 100% (respectively) of non-child abuse homicides of children 13-17 years old being killed by a firearm. This is consistent with the CDC which reports that most homicides involve a firearm.<sup>34</sup>

**Figure 11-1** Non-Child Abuse Youth Homicides by Age Group (2008)



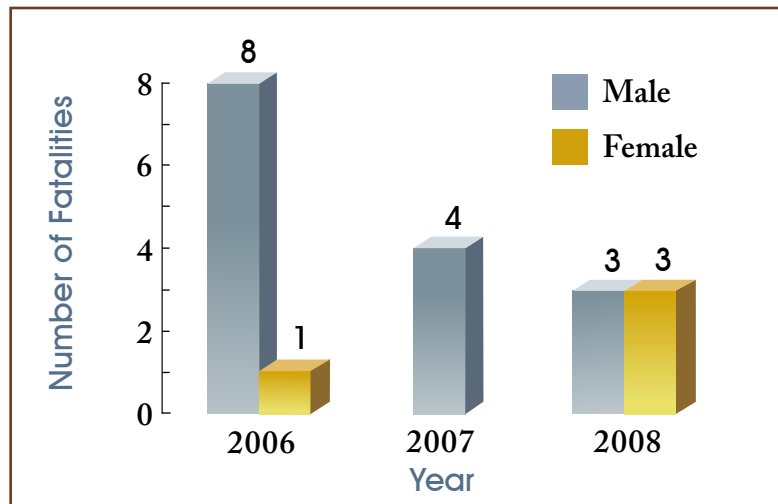
<sup>33</sup>Puzzanchera C. Juvenile Arrests 2008. Juvenile Justice Bulletin. Washington, DC: Office of Juvenile Justice and Delinquency Prevention; 2009. [2009 December]. Available from <http://www.ncjrs.gov/pdffiles1/ojdp/228479.pdf>

<sup>34</sup>National Center for Injury Prevention and Control. CDC Injury Fact Book. Atlanta (GA): Centers for Disease Control and Prevention; 2006.

## Gender

In 2008, there were an equal number of female and male non-child abuse homicides reviewed by the CFNFRB. However, in past years, there had been more male victims than female. See Figure 11-2. The CFNFRB's data from 2006 to 2008 showed that the fatality rate was .47 (per 100,000) for males and .13 for females. This data corresponds with the U.S. Department of Justice, which states that the murder rate for male victims ages 12-17 was more than three times the female rate in 2000.<sup>35</sup>

**Figure 11-2** Non-Child Abuse Homicides by Gender



## Ethnicity

Black (non-Hispanic) children are often considerably overrepresented in many types of child fatalities; unfortunately non-child abuse homicides are not an exception. As shown in the table below, the majority of non-child abuse homicides are of Black (non-Hispanic) children. Not only are the numbers of fatalities in this race category higher than all other race/ethnic groups combined; the fatality rate of Black (non-Hispanic) children is approximately five times higher than that of White (non-Hispanic) and Hispanic (all races) children.<sup>36</sup> The CFNFRB's data has been consistent with the U.S. Department of Justice, who reports that "between 1980-2000, 52% of murder victims were Black, 46% were White, and the remaining victims were American Indian, Alaska Native, Asian, or Pacific Islander".<sup>37</sup> Data from 2006-2008 shows that New Jersey has a lower percentage of White (non-Hispanic) non-child abuse homicide victims but a more significant number of Hispanic (all races) victims than national statistics. Between 2006 and 2008, 78.9% of victims were Black (non-Hispanic), 5.3% were White (non-Hispanic), 15.8% were Hispanic (all races) and 0% were multi-racial, American Indian, Alaska Native, Asian, or Pacific Islander.

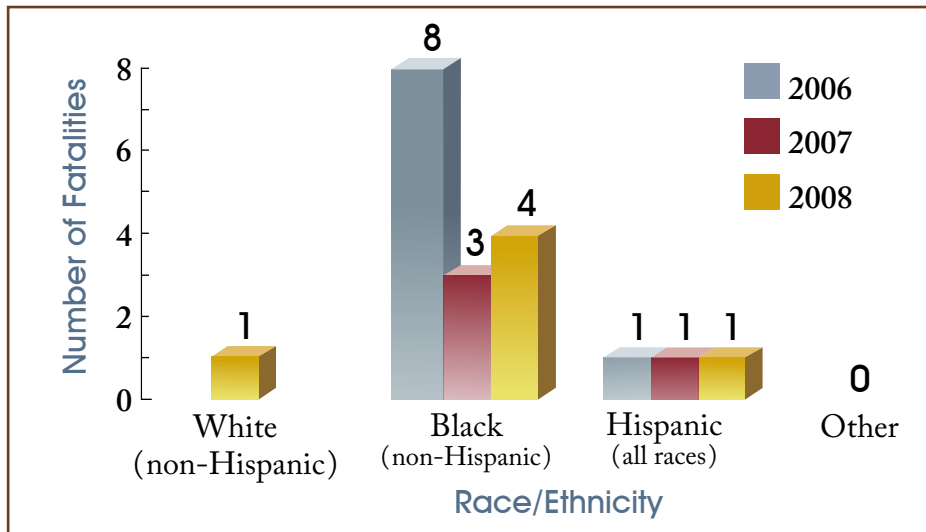
<sup>35</sup>Trends in the Murder of Juveniles: 1980-2000, Juvenile Justice Bulletin, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice; September 2004.

<sup>36</sup>The African American fatality rate in 2008 was 1.32, the White (non-Hispanic) fatality rate was .27 and the Hispanic fatality rate was .24. Rates were calculated using population data from The Annie E. Casey Foundation, KIDS COUNT Data Center, [datacenter.kidscount.org](http://datacenter.kidscount.org)

<sup>37</sup>Trends in the Murder of Juveniles: 1980-2000, Juvenile Justice Bulletin, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice; September 2004.

Figure 11-3

### Non-Child Abuse Homicides by Race/Ethnicity

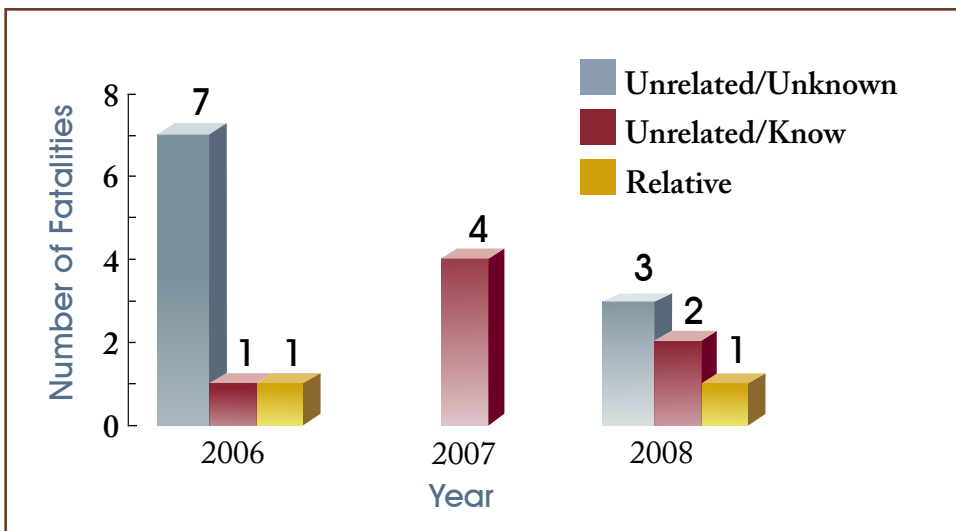


### Who were the Perpetrators?

Often in homicides committed by an individual other than a parent, the perpetrator is more often unrelated and unknown to the victim. In 2008, victims were not acquainted with the perpetrator in 50% of the homicides. They were unrelated but acquainted with the perpetrator 33.3% of the time and were related to the perpetrator 16.7% of the time. See Figure 11-4 below.

Figure 11-4

### Victim-Perpetrator Relationships (2008)



## Risk Factors

There are certain risk factors which place children at a greater risk of becoming a victim of murder perpetrated by non-caregivers. The Department of Justice attributes the increase in the number of teenagers murdered between the late 80s and early 90s, to the rise in child poverty, expansion of gang activity, spread of crack cocaine and drug market competition, and increased availability of handguns.<sup>38</sup> The CFNFRB noted that in 2008, four out of the six children had one or more of the following risk factors; including but not limited to criminal activity, associating with known gang members/being involved in a gang, substance abuse, mental illness, runaway behavior, school and behavioral problems. Two of these children were involved in the Juvenile Justice Commission (JJC) system and the same had lived in residential facilities to address their behavioral issues. The two other children did not have any known risk factors. In 2007, all of the children who died as a result of non-child abuse homicide incidents presented at least one of the above mentioned risk factors. And in 2006, only three of the nine children who were killed in non-child abuse homicides had no known risk factors. Although the presence of risk factors does not necessarily mean that a child will end up becoming a victim of a crime, service providers should be aware of these risk factors in order to construct the most appropriate intervention or plan for the child.

- Youth homicide victims of gun violence were predominately African American males.
- The majority of youth homicide victims had risk factors such as, criminal activity, gang involvement, substance abuse, mental illness, runaway behavior, and school problems.

<sup>38</sup> Homicides of Children and Youth; Juvenile Justice Bulletin, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice; October 2001.

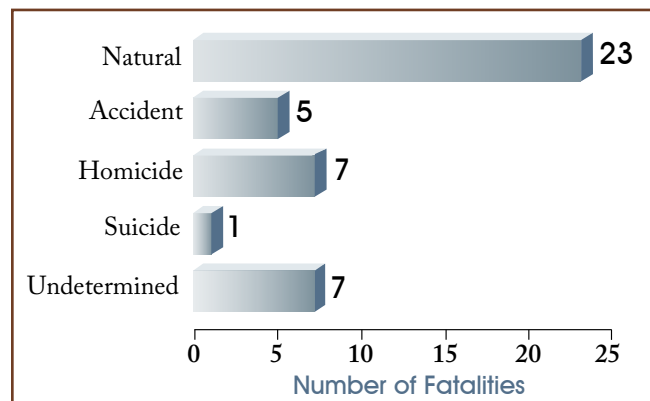
# Division of Youth and Family Services (DYFS)

The Division of Youth and Family Services (DYFS), is New Jersey's child protection and child welfare agency within the Department of Children and Families (DCF). DYFS' mission is to ensure the safety, permanency and well-being of children and to support families. DYFS is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment. DYFS is comprised of a Central Office, 12 Area Offices overseeing 47 Local Offices, and the state Child Abuse/Neglect Hotline known as the State Central Registry (SCR). DYFS also operates three Residential Treatment Centers for youth with intensive behavioral health needs.

Reports of suspected abuse or neglect or concerns for child welfare are screened through SCR (Statewide Central Registry), a centralized screening center at 1-877-NJ ABUSE (1-877-652-2873). SCR receives approximately 17,000 reports each month<sup>39</sup> of possible child abuse and neglect 24 hours a day, seven days a week. Of these calls, approximately 5,000 to 6,000 referrals each month statewide are forwarded to one of the 47 DYFS Local Offices for investigation or assessment of child welfare needs, or one of the four Institutional Abuse Investigation Units (IAIU), responsible for the investigation of alleged abuse or neglect occurring in child care centers, schools, resource homes, residential treatment centers, and correctional facilities. SCR screeners obtain relevant information from callers and forward the reports for appropriate field response to DYFS, IAIU, or Special Response Unit (SPRU; for after-hours, weekend, and holiday response).

As of June 2009, there were approximately 48,500 children whose families were receiving DYFS services.<sup>40</sup> In 36% (68 of 190) of cases reviewed by Board, or one of its regional teams, DYFS was involved with the families when the death or near fatality occurred or within 12 months preceding the child's death or near fatality. Of these 68 families, almost two thirds (43) were receiving some type of DYFS intervention (child welfare assessment, protective service investigation, or supervision) at the time of the child's death or near fatal injury.

**Figure 12-1** Fatalities with DYFS Supervision by Manner

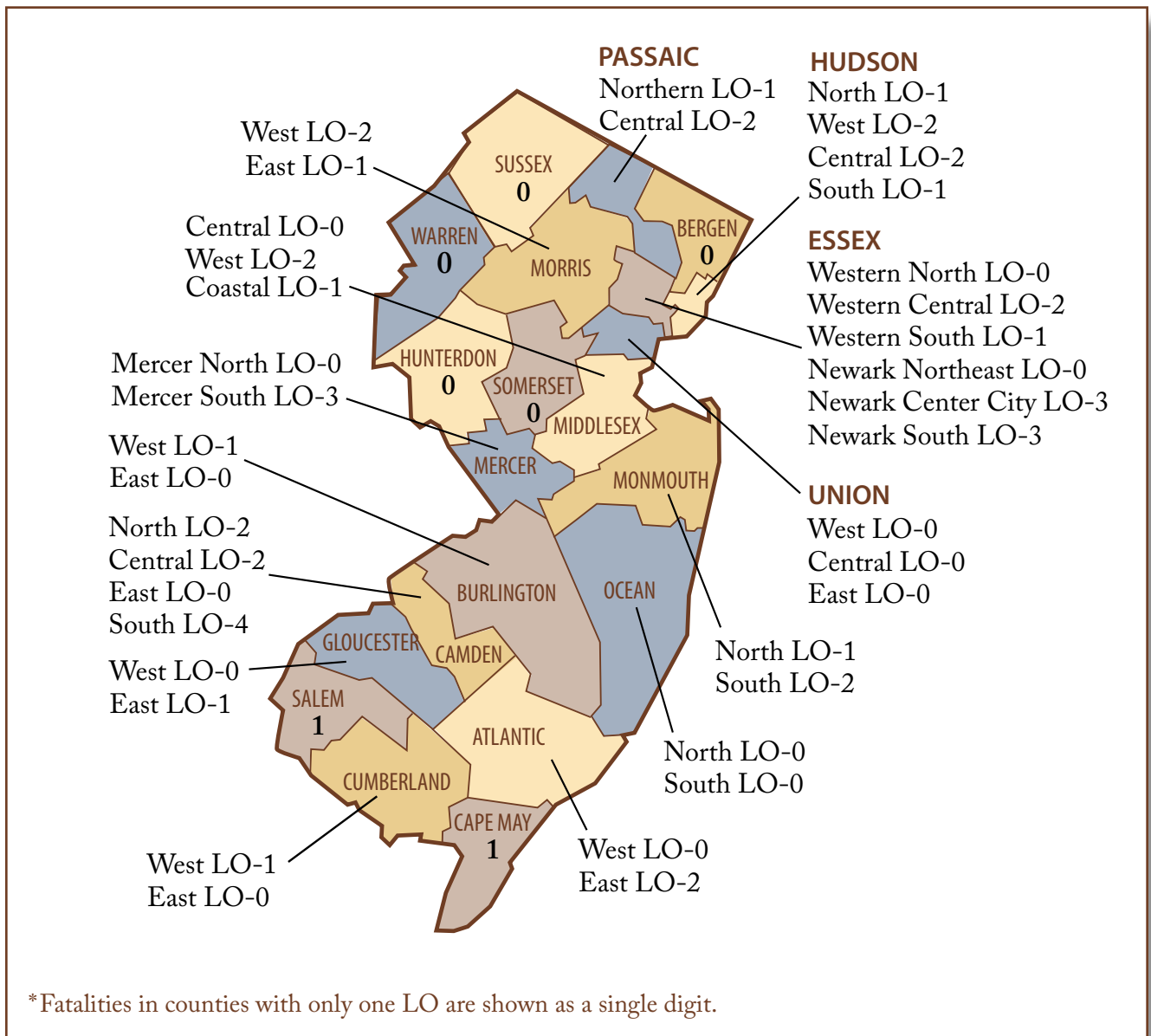


<sup>39</sup> Department of Children and Families (2009) Annual Agency Performance Report, New Jersey Department of Children and Families. Retrieved from [nj.gov/dcf/about/DCFAnnualAgencyPerformanceReport\\_12.15.09.pdf](http://nj.gov/dcf/about/DCFAnnualAgencyPerformanceReport_12.15.09.pdf), Pg. 5

<sup>40</sup> Department of Children and Families (2009) Annual Agency Performance Report, New Jersey Department of Children and Families. Retrieved from [nj.gov/dcf/about/DCFAnnualAgencyPerformanceReport\\_12.15.09.pdf](http://nj.gov/dcf/about/DCFAnnualAgencyPerformanceReport_12.15.09.pdf), Pg. 7

There were eight children whose families who had received DYFS services 12 months or longer prior to the death or near fatality; and 17 children who DYFS had terminated involvement within the 12 months preceding death or near fatality. The CFNFRB found a higher incidence of fatalities with open DYFS cases in Essex and Camden counties. See Figure 12-2. The higher incidence of fatalities in Essex and Camden counties is not evidenced by a higher number of Child Protective Service (CPS) referrals. According to data from the Department of Children and Families, in 2006 Camden county had the fifth highest CPS rate per 1000 children at 33.3 (4473 referrals) and Essex County had the tenth highest CPS rate at 26.6 (5604 referrals).<sup>41</sup>

**Figure 12-2** Fatalities on Open DYFS Cases by Local Office (LO)\*



<sup>41</sup> [http://www.state.nj.us/dcf/home/childdata/CPS\\_rate2.pdf](http://www.state.nj.us/dcf/home/childdata/CPS_rate2.pdf)



## FATAL AND NEAR FATAL INJURIES DUE TO ABUSE OR NEGLECT

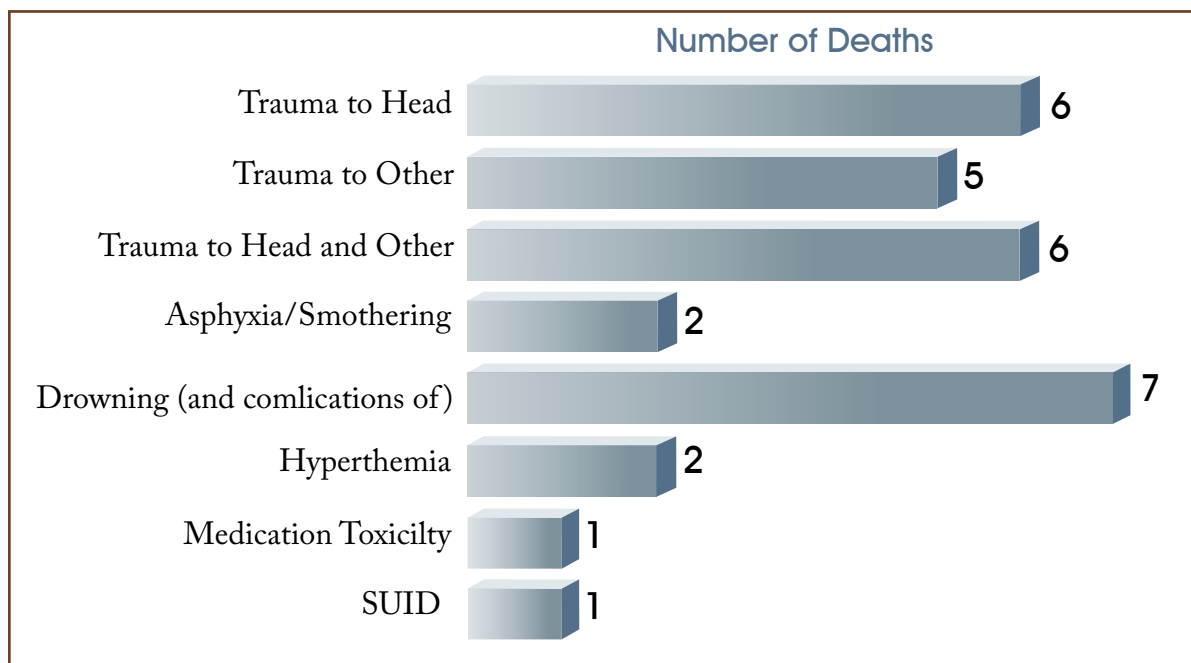
Eighteen percent of the deaths and near fatal cases reviewed in 2009 resulted from child abuse or neglect. Under the Child Abuse Prevention and Treatment Act, child abuse and neglect is defined as “at minimum, acts or failures to act by parents or ‘caretakers’ resulting in death, serious physical or emotional harm, sexual abuse or exploitation, or acts or failures to act presenting an imminent risk of serious harm.”<sup>42</sup> Thirty children lost their lives and five (of six) children are now living with chronic impairments due to the action, or inaction, of their caregiver.

**Twenty nine of the 36 children who died or suffered near fatal injuries as a result of abuse or neglect had no active DYFS intervention at the time of their deaths.**

### Cause of Death

According to the World Report on Violence and Health and the U.S. Administration on Children and Families (ACF), child maltreatment caused by blunt trauma to the head or violent shaking is the leading cause of maltreatment death followed by injury to the abdomen. Intentional suffocation has also been extensively reported as a cause of death.<sup>43</sup> New Jersey’s fatal injuries to the head, torso, and a combination of the two, were consistent with information from the World Report on Violence and Health. In 2008, there were six fatalities caused by trauma to the head only, five fatalities caused by trauma to other body parts only (mainly the abdomen) and six fatalities caused by trauma to the head and other body parts, seven fatalities due to drowning or complications after a near drowning, two fatalities due to asphyxia, two fatalities due to hyperthermia, one SUID fatality, and one fatality due to adverse effects of medication.

**Figure 12-3 Abuse/Neglect Fatalities by Cause of Death (2008)**



<sup>42</sup>Public Law 104-235; Section 111

<sup>43</sup>Child Abuse and Neglect by Parents and Other Caregivers, World Report on Violence and Health, Pg. 60

## WHO WERE THE PERPETRATORS OF FATAL AND NEAR FATAL ABUSE OR NEGLECT?

In New Jersey, there were a total of 36 abuse or neglect incidents reviewed in 2008,<sup>44</sup> six of which were near fatal incidents. In all but one incident, DYFS substantiated the alleged perpetrator(s).<sup>45</sup> Almost 70 % of fatal or near fatal child abuse incidents (25 out of 36) involved at least one or both biological parents, six incidents involved a male paramour, in four of the incidents the perpetrator was never identified, and in one case the perpetrator was a babysitter (see Table 12-4).

A paramour is defined as a parent's unmarried partner or significant other, including a current or ex-boyfriend or girlfriend who is, or may be, in a caregiving role for the child, whether residing in the home or frequenting the home.

Figure 12-4 Perpetrator Type and Frequency (2008)

Perpetrator	Frequency	Percentage
Biological mother	11	30.5%
Biological father	7	19.4%
Both biological parents	5	13.9%
Paramour	6	16.7%
Paramour and mother	2	5.6%
Unknown	4	11.1%
Babysitter	1	2.8%
<b>TOTAL</b>	<b>36</b>	<b>100%</b>

The CFNFRB's data from 2003 through 2008 revealed that in New Jersey the percent of mothers substantiated for fatal or near fatal abuse and neglect is consistently higher than that of fathers and paramours (See Figure 12-5). Nationally, the number of women who are perpetrators of abuse or neglect (56%) is also higher than the number of men (42%).<sup>46</sup> A likely explanation for this discrepancy is that women are more often the primary, if not only, caregivers for children. In the future, the CFNFRB plans to collect information regarding caregivers in order to determine whether conclusions and recommendations for support services can be made regarding family structure to minimize child abuse fatalities.

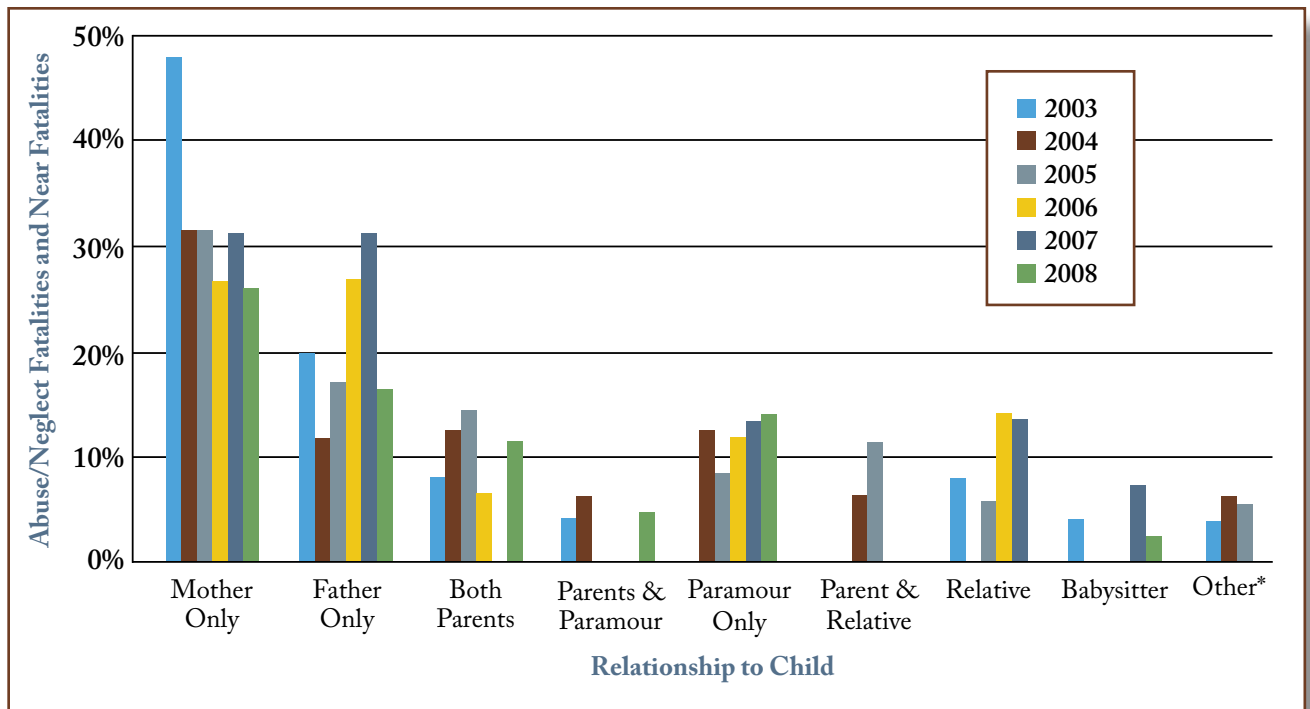
<sup>44</sup>Due to the CFNFRB's goal to review cases in the same calendar year, one of the 2008 CAPTA incidents was reviewed in the 2008 calendar year.

<sup>45</sup>In this case, the referral was not coded with allegations of abuse or neglect regarding the minor parents' actions but neglect was substantiated on the maternal grandmother where the baby was residing.

<sup>46</sup>U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2009) Child Maltreatment-Facts at a Glance. Retrieved from [www.cdc.gov/violenceprevention/pdf/CM-DataSheet-a.pdf](http://www.cdc.gov/violenceprevention/pdf/CM-DataSheet-a.pdf)

Figure 12-5

Perpetrators of Abuse/Neglect Fatalities and Near Fatalities



\*The "other" category represents a perpetrator who could not be counted in any other category. This includes facility staff, resource parents, adult siblings, etc.

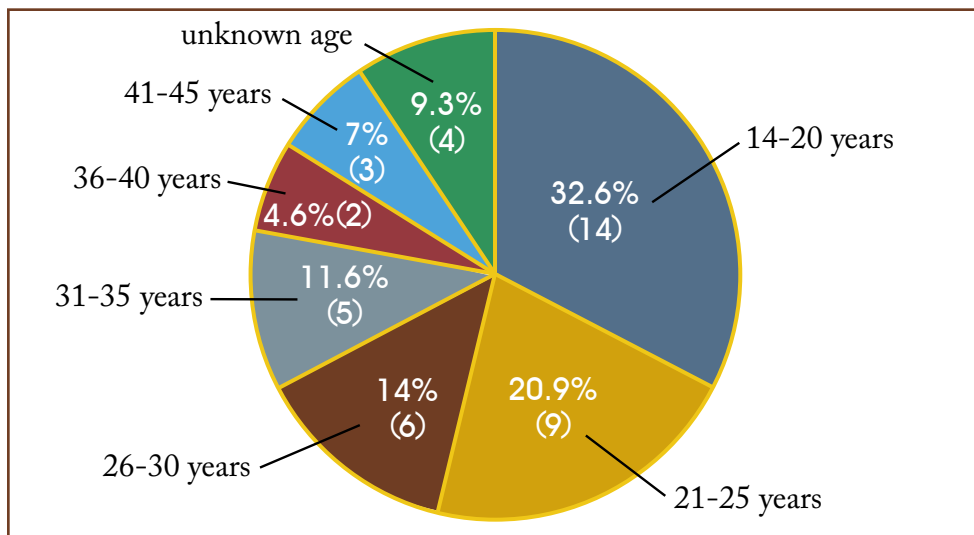
## Age of Perpetrators

A significant finding in the CFNFRB's 2008 review data suggests that younger caregivers are at an increased likelihood of inflicting fatal abuse or neglect. There were 35 perpetrators<sup>47</sup> ranging in age from 14 to 42 years of age. For the purpose of comparison, age was separated into seven categories; 14-20 years old, 21-25 years old, 26-30 years old, 31-35 years old, 36-40 years old, 41-45 years old, and unknown age. Together, the 14-20 year old and 21-25 year old age group accounted for over half of the perpetrators of fatal abuse or neglect (23 perpetrators; 53.5%). The 26-30 year old age group represented 14% (6), 31-35 year old age group represented 11.6% (5), 36-40 year old age group represented 4.6% (2), 41-45 year old age group represented 7% (3), and perpetrators of unknown age made up 9.3% (4) of perpetrators.

<sup>47</sup>Of the 36 fatal abuse/neglect incidents reviewed, 30 were fatalities. There were 35 perpetrators of abuse/neglect fatalities because more than one person can be substantiated in each incident.

Figure 12-6

## Ages of Fatal and Near Fatal Abuse/Neglect Perpetrators (2008)



The CFNFRB found that the median age of female perpetrators causing fatal and near fatal injuries in 2008 was 23.7 years old and 26.5 years for male perpetrators of fatal and near fatal abuse.<sup>48</sup> New Jersey's median age was younger than national median ages for both female and male perpetrators. National data reports the median age for female perpetrators is 30 and 33 for male perpetrators.<sup>49</sup>

An interesting find in the data collected by CFNFRB shows paramours were held criminally responsible for their involvement in a fatality 100% (eight out of eight perpetrators charged) of the time. This is a distinct contrast to the 47% of parent perpetrators criminally charged in the death of their child (14 out of 30 parent perpetrators (at the time of this writing, two criminal investigations were still ongoing and no formal charges had been filed against parents substantiated by DYFS for abuse or neglect.) This variance may be explained by the fact that all CAPTA fatalities attributed to a paramour or partner were certified homicides by the medical examiner while fatalities due to abuse or neglect by parents were certified homicide, accident, or undetermined. In all of the fatalities involving parents as perpetrators and certified a homicide by the medical examiner, parents were charged with a crime. In all but one, of the fatalities certified by the medical examiner as an accident or undetermined, the parents were not charged with a crime in connection with the death. In the exception, the parents were held criminally responsible for their child's accidental death because the investigation revealed a pattern of neglect. In that case, a six year old was caring for his four younger siblings, ranging in age from six months to four years old, while his parents slept. The child then left the home and his 22 month old sibling drowned in a bathtub.

DYFS has been particularly sensitive to the trend of non-parents abusing or neglecting children and fashioned the paramour policy around this issue in 2004 to guide workers in conducting a more extensive

<sup>48</sup>These figures are based on known perpetrator ages

<sup>49</sup>U.S. Department of Health and Human Services-Administration for Children and Families: Administration on Children, Youth, and Families; Children's Bureau. Child Maltreatment 2007, Retrieved from [www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf](http://www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf), P.65

investigation in these circumstances. This includes determining how involved the paramour is in the family's life, conducting criminal history (Promis/Gavel) and Child Abuse Record Index (CARI) checks, gathering collateral information, observing the paramour's attitude towards children, and interviewing children and non-offending parents in a neutral environment. The number of paramour perpetrators has fluctuated; however, in 2008 paramours who killed their partner's children was higher than any other year since 2003, with paramours' direct actions resulting in eight of the 30 deaths (26.7%).

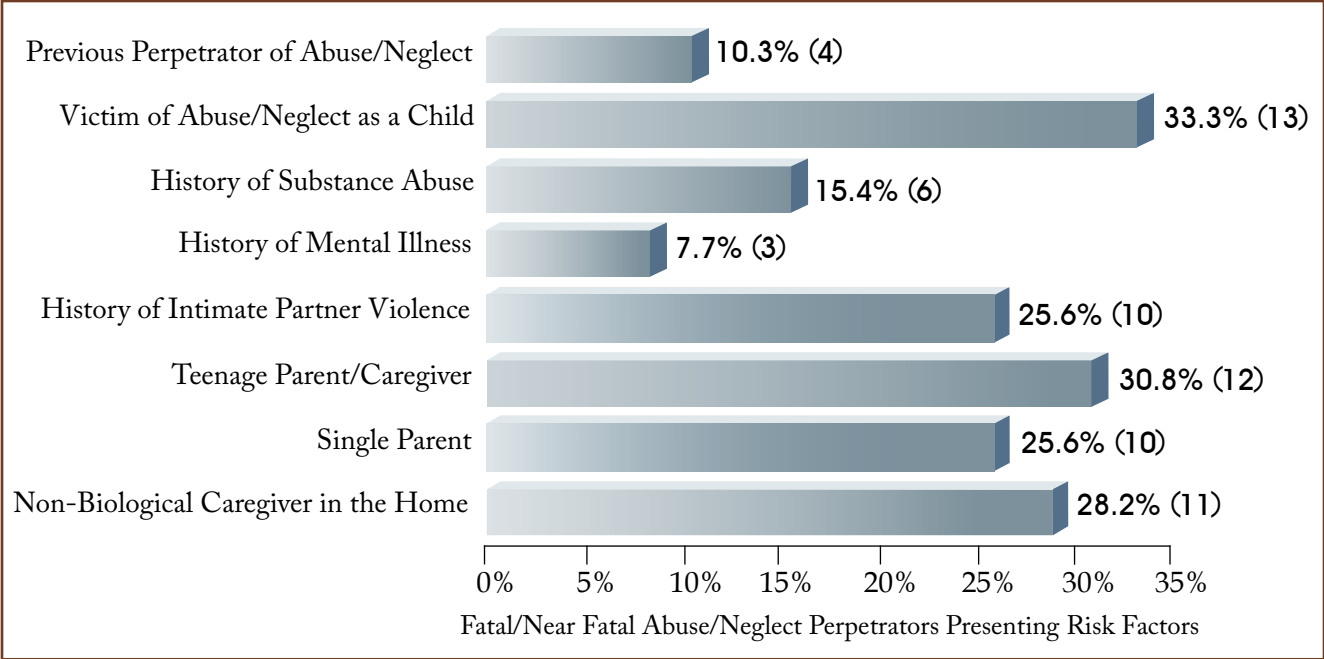
### RISK FACTORS FOR ABUSE AND NEGLECT

According to the CDC “research shows that child maltreatment is closely linked with other forms of violence in adulthood such as intimate partner violence. Furthermore, studies have also shown that witnessing or experiencing abuse as a child can increase the risk factors for becoming a victim or perpetrator of violence.” Other risk factors include parents’ history of child abuse in family of origin, family disorganization, dissolution, and non-biological, transient caregivers in the home (e.g., mother’s male partner).

- 35.1% of perpetrator households included non-biological parents.
- 32.4% perpetrators of fatal or near fatal child abuse were victimized themselves as a child.
- 27% had a known history of intimate partner violence.

The CFNFRB examined the social risk factors commonly associated with child abuse and neglect. The data shows that of the known perpetrators of fatal or near fatal injuries, 75.7% (28 of 37 perpetrators) experienced at least one of the above risk factors prior to a fatal or near fatal abuse or neglect incident. See Figure 12-7.

**Figure 12-7** Risk Factors Observed in Child Abuse and Neglect Fatalities and Near Fatalities (2008)



The CFNFRB data revealed that almost a third of the cases had two risk factors. Thirteen out of 39 (33.3%) known perpetrators of fatal or near fatal abuse or neglect were themselves, victims of abuse or neglect as a children. Ten of the 39 (25.6%) perpetrators had a known history of intimate partner violence. The next highest incidence of a risk factor was attributed to non-biological partners of parents, with 11 paramours being present in the home (28.2%). Other risk factors seen by perpetrators in reviews conducted by the CFNFRB were substance abuse (15.4%), mental illness (7.7%), and teenaged parents (30.8%). Although each of these risk factors separately does not present a major trend, it is important to consider these factors, especially when there is more than one risk factor present, when assessing families.

## ABUSE AND NEGLECT FATALITIES

The CDC identifies certain risk factors for victimization. These include children younger than 4 years of age and children with special needs that may increase caregiver burden.<sup>50</sup> The CFNFRB has consistently seen several trends regarding child fatalities due to maltreatment. These trends are significant in that there is a tendency for children of a certain age, gender, or race to be at a greater risk of being fatally abused or neglected.

### Age

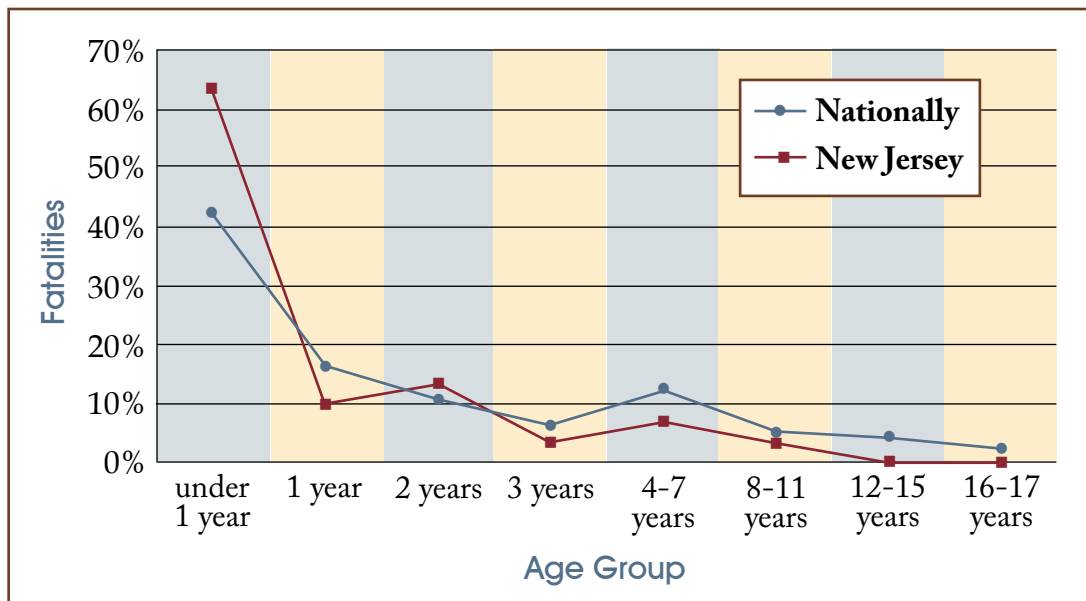
According to the U.S. Department of Health and Human Services-Administration for Children and Families (DHHS-ACF), 1,760 children died in the United States in 2007 due to abuse or neglect; 75.7% of the victims were younger than four years old.<sup>51</sup> The CFNFRB's review of cases corroborated the CDC report that children under four years of age are most often the victims of injury resulting in death from abuse or neglect; with 27 of the 30 abuse or neglect fatalities being of children under four years old (90%). However, in New Jersey the majority (63.3%) of the 30 children who died as a result of abuse or neglect, were under one year old, which is significantly greater than national statistics. Nationally, 42.2% of fatalities due to abuse and neglect were of children under one year old. Of note, as shown in the table below, New Jersey's statistics of fatalities due to abuse and neglect were lower in every age group other than the "under 1" and "2 years old" groups. See Figure 12-8.

<sup>50</sup>U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (2009) Child Maltreatment: Risk and Protective Factors, Retrieved from [www.dcd.gov/ViolencePrevention/childmaltreatment/riskprotectivefactors.html](http://www.dcd.gov/ViolencePrevention/childmaltreatment/riskprotectivefactors.html)

<sup>51</sup>U.S. Department of Health and Human Services-Administration for Children and Families: Administration on Children, Youth, and Families; Children's Bureau. Child Maltreatment 2007, Retrieved from [www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf](http://www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf), P.55

Figure 12-8

Percentage of Fatalities: New Jersey vs. National

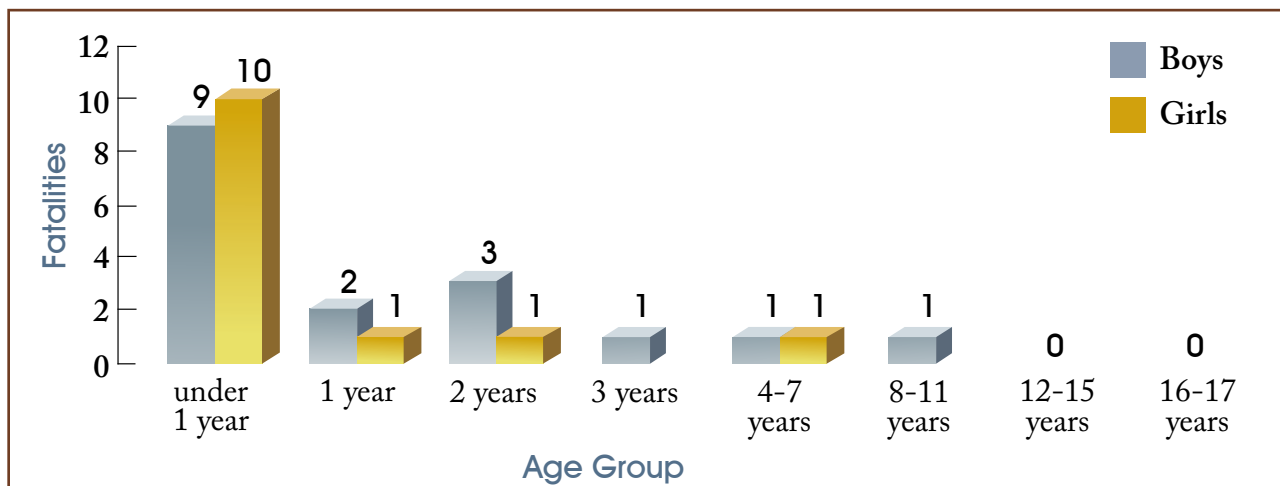


## Gender

CFNFRB data for 2008 fatalities demonstrates that in New Jersey, boys are more often fatally abused in almost every age group; except under one year old, where there were nine male fatalities and 10 female fatalities. Figure 12-9 shows the number of fatalities decreased significantly in children one year and older. This corroborates data obtained by the U.S. Department of Health and Senior Services-Administration for Children and Families; which shows that nationally, fatality rates decrease significantly with age; with a sharp decrease in the number of fatalities in boys and girls one year and older.<sup>52</sup>

Figure 12-9

Fatalities by Gender and Age Group (2008)



<sup>52</sup>U.S. Department of Health and Human Services-Administration for Children and Families: Administration on Children, Youth, and Families; Children's Bureau. Child Maltreatment 2007, Retrieved from [www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf](http://www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf), P. 61, Table 4-3

The average fatality rate in the United States in 2007 for male children was 2.59<sup>53</sup> and 2.07 for female children.<sup>54</sup> National data for 2008 fatality rates were unavailable; however, in New Jersey the 2007 fatality rate was 1.80 for male children and 1.49 for female children and in 2008, the fatality rate was 1.62 for males and 1.30 for females.<sup>55</sup> These rates are much lower than national fatality rates; however, New Jersey has to continue to implement preventative services to further lower the number of child fatalities.

## Race/Ethnicity

Although racial/ethnic disparities among injury death rates decreased in absolute terms as age increased,<sup>56</sup> the CFNFRB has seen a consistently disproportionate number of Black (non-Hispanic) children who die as a result of abuse or neglect. This year, the CFNFRB also saw a disproportionate number of fatalities in Hispanic children of all races. The total number of children in New Jersey as of 2008 was 2,047,582. Of these children 54% were White (non-Hispanic), 15% were Black (non-Hispanic), 21% were Hispanic (all races), and 10% were American Indian, Alaskan Native, Asian, Pacific Islander, or children of multiple races.<sup>57</sup> The population of White (non-Hispanic) children is more than triple the population of Black (non-Hispanic) children in New Jersey, yet Black (non-Hispanic) children accounted for more than twice the number of deaths due to abuse or neglect than White (non-Hispanic) children. Similarly, the Hispanic (all races) population is less than half of the population of White (non-Hispanic) children but has three times the number of fatalities. In 2008,<sup>58</sup> New Jersey lost 12 Black (non-Hispanic) children (40%), four White (non-Hispanic) children (13.3%), 12 Hispanic (all races) children (40%), and two American Indian, Alaska Native, or Asian, Pacific Islander, or multiple race (6.7%) children due to abuse or neglect. The imbalance between Black (non-Hispanic) child abuse/neglect fatalities and children of other race/ethnicities is even more apparent when population<sup>59</sup> is factored in. See Figure 12-10

The population of White (non-Hispanic) children is more than triple the population of Black (non-Hispanic) children in New Jersey, yet Black (non-Hispanic) children accounted for more than twice the number of deaths than White (non-Hispanic) children and although the Hispanic (all races) population is less than half of the population of White (non-Hispanic) children, Hispanics (all races) experienced three times the number of fatalities.

<sup>53</sup> All fatality rates are per 100,000

<sup>54</sup> U.S. Department of Health and Human Services-Administration for Children and Families: Administration on Children, Youth, and Families; Children's Bureau. Child Maltreatment 2007, Retrieved from [www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf](http://www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf), P. 61 Table 4-3

<sup>55</sup> The fatality rate was calculated by the number of fatalities divided by the population of each sex. In 2007 the population of boys was 1,055,316 and was 1,005,265 for girls. In 2008 the population of boys was 1,049,056 and was 998,526 for girls. Fatalities rates for each gender and age group were unable to be calculated for New Jersey, as this type of data was unavailable.

<sup>56</sup> U.S. Department of Health and Human Services, Centers for Disease Control (2008 May 18) Fatal Injuries Among Children by Race and Ethnicity-United States, 1999-2002, Morbidity and Mortality Weekly Report, 56(SS05), Pg. 3, Retrieved from [www.cdc.gov/mmwr/preview/mmwrhtml/ss5605a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5605a1.htm)

<sup>57</sup> The Annie E. Casey Foundation, KIDSCOUNT Data Center, <http://datacenter.kidscount.org>

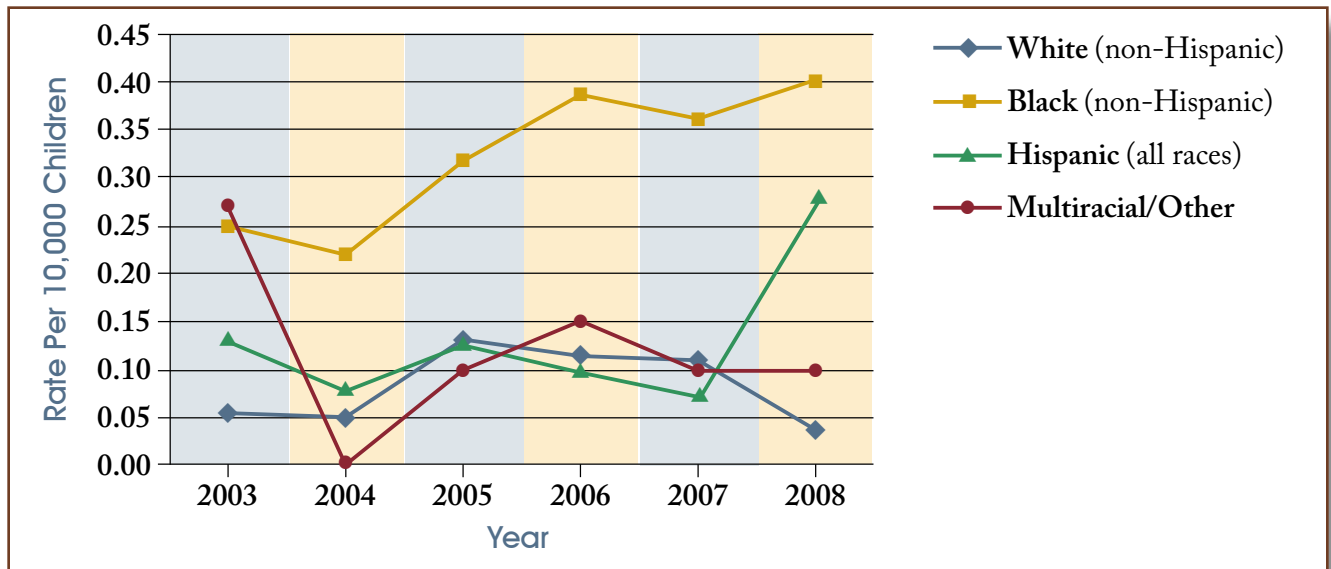
<sup>58</sup> There were three 2009 fatalities reviewed with 2008 fatalities. These victims are included in the figures for 2008.

<sup>59</sup> Population data was retrieved from The Annie E. Casey Foundation, KIDSCOUNT Data Center, <http://datacenter.kidscount.org>



Figure 12-10

## Child Abuse and Neglect Fatality Rate by Race/Ethnicity



The CFNFRB's data is inconsistent with DHHS-ACF data which shows that nationally, 41.1% of fatalities were White (non-Hispanic), 26.1% were Black (non-Hispanic), 16.9% were Hispanic (all races), 4.8% were American Indian, Alaska Native, Asian, Pacific Islander, or multiple race categories, and 11.1% were of unknown race.<sup>60</sup> The CDC also had similar data with regard to fatalities rates by race. If these national figures were accurate in New Jersey, of the 30 fatalities approximately 12 would be White (non-Hispanic), eight would be Black (non-Hispanic), five would be Hispanic (all races), two would be American Indian, Alaskan Native, Asian, Pacific Islander, or multiple race, and three would be of unknown race.

## NEAR FATALITIES

A near fatality is defined as a case in which a child is in serious or critical condition, as certified by a physician.<sup>61</sup> At this point in time, the Board has only reviewed cases of near fatal injuries when abuse or neglect is alleged or DYFS has current DYFS involvement. Only one of the seven children was open under DYFS supervision at the time of the near fatal incident; however, DYFS did investigate all seven incidents. Six of the seven (85.7%) near fatalities were determined to be due to abuse. One reported incident was determined to be unfounded because the child sustained accidental injuries as a result of a television falling on her. In 2008, all seven near fatal injuries occurred as a result of trauma to the head.

<sup>60</sup>U.S. Department of Health and Human Services-Administration for Children and Families: Administration on Children, Youth, and Families; Children's Bureau. Child Maltreatment 2007, Retrieved from [www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf](http://www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf), P. 56

<sup>61</sup>Section 2 of P.L.1987, c.175 [C.9:6-8.84]

## Types of Injuries

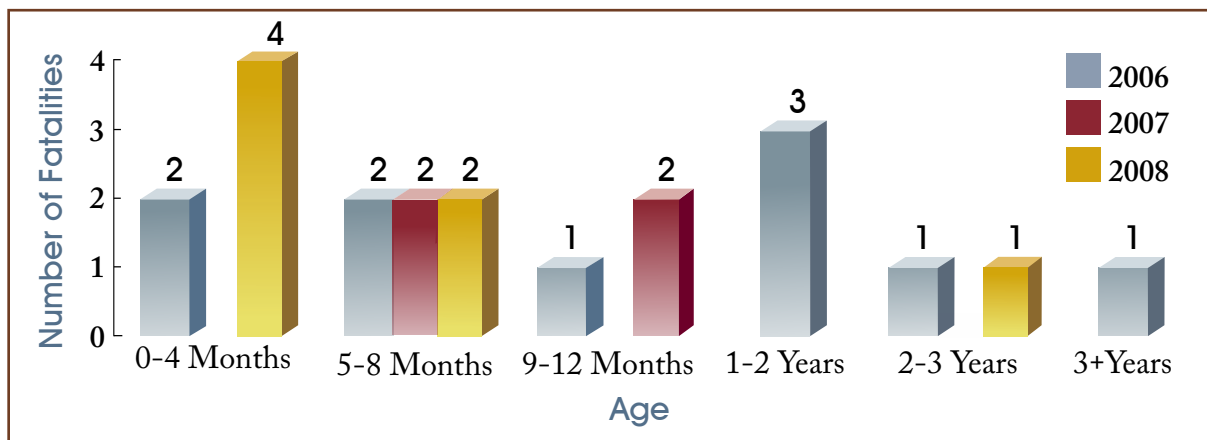
Non-Accidental Blunt Force Trauma, is the cause of severe physical injury and death in infants, occurring in 21.0-32.2 infants aged <1 year (per 100,000).<sup>62</sup> The World Report on Violence and Health reports that “there is evidence that about one-third of severely shaken infants die and that the majority of survivors suffer long-term consequences such as mental retardation, cerebral palsy, or blindness”.<sup>63</sup> The CFNFRB noted that with the exception of one child, every near fatal injury occurring in 2008 was the result of abusive head trauma.

Six of seven near fatalities were due to abusive head trauma.

## Age

The data collected by the CFNFRB over a three year period from 2006 to 2008 revealed that 71.4% of near fatal injuries occurred in children under one year old (15 of the 21 near fatalities during that time period). In 2008, all but one of the victims of near fatal head trauma were six months old or younger (85.7%). The exception was a 23 month old who suffered accidental head trauma when a television fell on her.

Figure 12-11 Near Fatal Incidents by Age and Year



## Gender

CFNFRB data shows that on average, over the past three years, there have been more incidents of near fatal injuries in male children. Although female and male children are equally likely to be victimized,<sup>64</sup> “male children appear to be at greater risk of harsh physical punishment”.<sup>65</sup> As referenced above, most of the children sustained abusive head trauma resulting in a near fatal status.

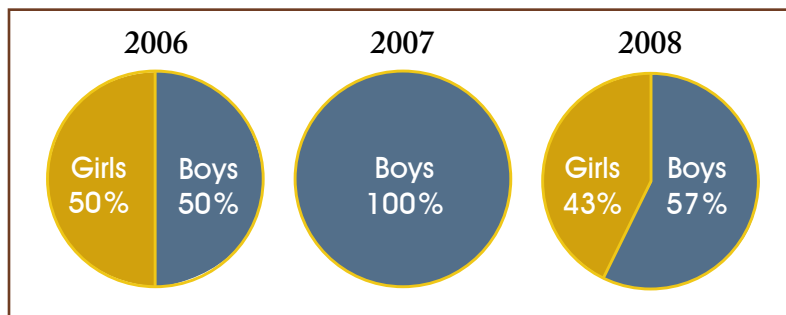
<sup>62</sup>U.S. Department of Health and Human Services, Centers for Disease Control (2008 April 4) Nonfatal Maltreatment of Infants-United States, October 2005-September 2006, Morbidity and Mortality Weekly Report, 57(13), Pg. 339, Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5713a2.htm>

<sup>63</sup>World Health Organization, Department of Injuries and Violence Prevention, World Report on Violence and Health, Retrieved from [www.who.int/violence\\_injury\\_prevention/violence/global\\_campaign/en/chap3.pdf](http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap3.pdf), P. 61

<sup>64</sup>U.S. Department of Health and Human Services-Administration for Children and Families: Administration on Children, Youth, and Families; Children's Bureau. Child Maltreatment 2007, Retrieved from [www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf](http://www.acf.hhs.gov/programs/cb/pubs/cm07/cm07.pdf), P. 25

<sup>65</sup>World Health Organization, Department of Injuries and Violence Prevention, World Report on Violence and Health, Retrieved from [www.who.int/violence\\_injury\\_prevention/violence/global\\_campaign/en/chap3.pdf](http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap3.pdf), P. 66

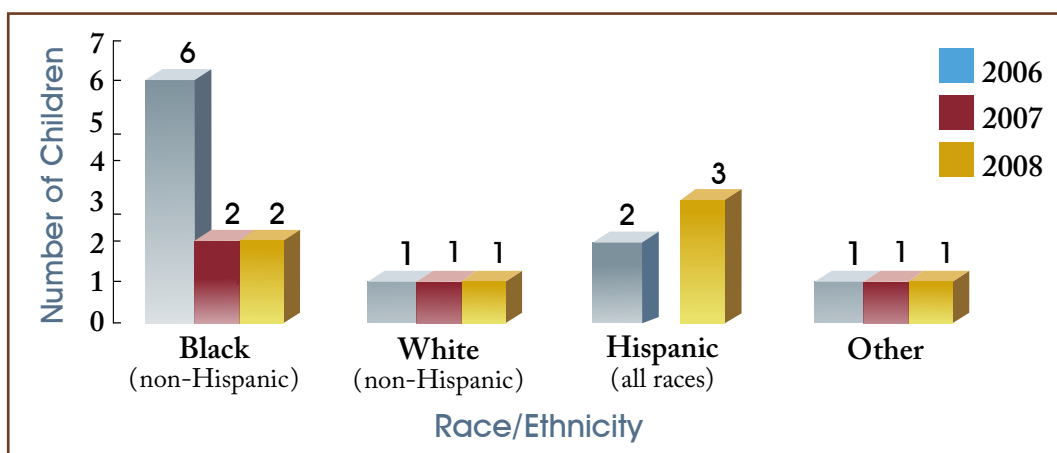
**Figure 12-12** Near Fatalities by Gender (2006, 2007, 2008)



## Race/Ethnicity

As Figure 12-13 shows, the number of near fatal incidents due to abuse has decreased since 2006 in New Jersey. In 2006, there were 10 near fatalities, four in 2007, and eight in 2008. CFNFRB data also reveals that near fatal abuse among Black (non-Hispanic) children has decreased but the number of Hispanic (all races) children suffering near fatal injury has increased slightly since 2006. It is difficult to determine whether there is a trend in relation to near fatal incidents and race/ethnicity; unlike those seen with fatal child maltreatment. Since 2006, a total of nine Black (non-Hispanic), five Hispanic (all races), three White (non-Hispanic), and three children of other or mixed race/ethnicity were almost killed and suffered permanent impairment.

**Figure 12-13** Race/Ethnicity of Near Fatally Injured Children



## Perpetrators of Near Fatal Abuse

In the six near fatalities due to maltreatment, both parents were substantiated for abuse on two cases, the father was substantiated for abuse on another case, and on three cases DYFS substantiated with an unknown perpetrator. In regards to the one near fatal incident deemed not to be an abuse or neglect incident, DYFS the allegation of neglect was unfounded due to accidental nature of the injuries. The perpetrators of these near fatal incidents ranged in age from 19-22; not including the three substantiations with unknown perpetrators. The average age of perpetrators of near fatal abuse/neglect in 2008 was 20.4 years old.

# Recommendations

## RECOMMENDATIONS TO THE DEPARTMENT OF CHILDREN AND FAMILIES

### *Division of Youth and Family Services*

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#### **Item # 1. Closing Cases Deemed High Risk**

The Risk Assessment is completed whenever a DYFS worker conducts a child abuse or neglect investigation on a new or existing case, when a new case is opened, or when a closed case is re-opened. The DYFS Risk Assessment tool, which is based on conditions that currently exist in the family and the family's prior history, does not provide a structured process for caseworkers and supervisory staff to demonstrate justification for closing cases involving children determined to be at high risk of future maltreatment.

In cases that are under DYFS supervision for less than six months, there is no requirement to conduct a Risk Re-assessment which would capture improvements in level of service compliance, insight into problematic behaviors, or caregiver's engagement in the case plan.

Risk factors such as mental health history, substance abuse history, a disabled child, or a parent history of abuse or neglect as a child, remain static. Therefore certain families would always meet high-risk criteria whenever an investigative risk assessment is completed. For example, the same risk level would be assigned on a risk assessment of a family whose primary caregiver successfully completed substance abuse treatment and has been abstinent from drugs, as that of a primary caregiver with a history of substance abuse who never entered into treatment.

#### **Recommendation #1**

DYFS develop a guideline for case managers and supervisory staff to determine when high-risk cases are appropriate to be closed when a Risk Re-assessment is not required. The guideline should provide staff with structured reasoning steps to demonstrate and document the rationale for closure of a case that may meet high-risk criteria by history, but with circumstances that are not captured on the Risk Assessment.

#### **Item # 2. Safe Sleep Education**

As this report established, an average of one infant per month died in New Jersey in 2008 as a direct result of suffocation, with overlay, co-sleeping, and wedging listed as the cause of death. Another 41% of the unexpected infant deaths included a notation on medical examiner reports that overlay during

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sleep was a contributing factor, or could not be ruled out as contributing to the cause of death. The Board recognizes that it is critically important to implement safe sleep education for various providers who come into contact with children and families. One agency capable of widespread implementation is the Department of Children and Families (DCF), who has direct contact with between 60,000 to 72,000 families per year through DYFS services. There is a need for greater collaboration between DCF, and the SIDS Center of New Jersey, who already provides risk reduction education outreach to medical and nursing staff, social welfare agencies, first responders, childcare providers, and the general public. The SIDS Center has made these programs available to local DYFS offices; however the programs have not been institutionalized.

### Recommendation #2

DYFS shall institutionalize safe sleep education within DCF's Child Welfare Training Academy to include caseworkers, Resource Family Support Workers, and Office of Licensing inspectors. DCF should also include risk reduction education during mandatory PRIDE training for prospective resource home parents, and should seek out the support of the SIDS Center of NJ who already provides this training to community foster care agencies.

### Item #3. Monthly Case Practice Newsletter

The CFNFRB has reviewed a multitude of child fatality cases over the last decade, and appreciates and recognizes the important role that DYFS plays in the investigation of many of these tragedies. Unfortunately, the Board has no means of routinely sharing findings ascertained through these reviews with frontline DYFS staff. A monthly case practice newsletter including a spotlight on certain child fatalities would be a useful instrument in highlighting good case practice, and in demonstrating lessons learned from flaws in current systems or practices. A caseworker or supervisor is more capable of catching a misstep, or recognizing precipitants by learning from previous case review outcomes.

### Recommendation #3

DYFS should create a case practice newsletter, or supplement existing newsletters, in order for DYFS staff to see shared common trends, pitfalls of challenging cases, avoiding case practice errors and comparisons with examples of good case practice.

### **Child Fatality Investigation**

According to N.J.S.A. 9:6-8.1, any person having reasonable cause to believe that a child has been subjected to child abuse, or acts of child abuse shall report the same immediately to the Division of Youth and Family Services. The statute requirements are fairly clear in reporting abuse or neglect; however, a dilemma occurs when multiple agencies become involved in the death of a child, with each agency having its own policy or protocol about their responsibilities and involvement. Occasionally, a gap occurs due to unclear expectations or role assignment of each agency involved. For example, when a fatality occurs, even though the police department, medical examiner's office, and hospital are all involved, a report may not be made to the State Central Registry, especially if the death is not deemed suspicious, because each of the agencies involved assumed that one of the other agencies made the report. This gap shows a need for uniformed structure and role assignment of the multidisciplinary respondents.

New Jersey currently lacks a statewide, multidisciplinary protocol for the investigation of child fatalities. The CFNFRB endorses and recommends that the Attorney General issue a directive mandating the implementation of the Child Fatality Multi-Disciplinary Investigation Protocol developed by Gloucester County Prosecutor Sean Dalton; which has been submitted for review and approval to the Office of the Attorney General. This protocol outlines the expectations, roles, and responsibilities of each agency involved in a child death investigation. A standard practice protocol such as this would ensure uniformity of action for those responding to a child death and initiating an investigation. This type of uniform standard would improve the quality and integrity of the information collected at the death scene, and the processing of that information. By clearly defining the roles and responsibilities of all parties responding to a child fatality, there will be greater consistency to systemic processes such as child welfare notification, legal authority collaboration, etc.

Retrospective reviews and comprehensive risk factor identification and correlation are dependant on the integrity of death scene information. What we do not learn from history we are destined to repeat. What we do not learn from examination of child fatalities leaves us vulnerable for reoccurrence.

Of particular interest for the Attorney General would be that this enhanced investigation procedure would improve future outcomes regarding those child fatalities in which a parent or caregiver is charged with a lesser degree of criminal culpability; such as child endangerment, aggravated assault, or child abuse, rather than being charged with homicide, in cases where the manner of death is certified as a homicide.

## RECOMMENDATION TO THE LEGISLATURE AND GOVERNOR

The Board has repeatedly recommended an amendment to the current legislation which has governed the Medical Examiner system since its beginning. Over the last decade the Board has observed inconsistent practices in county-based medical examiner offices, which impacts the quality of death scene investigations throughout the State. In total, 42 letters have been written by the Board and forwarded to County Medical Examiners, Regional Medical Examiners, or the Acting State Medical Examiner, detailing concerns identified during board and team fatality reviews, and resulting recommendations.

Those letters (including some with multiple concerns) included:

- ▶ **Twenty letters noting the review teams disagreement with the cause and/or manner of death determined by the medical examiner.**
- ▶ **Twenty letters noting concerns identified by the review team related to medical examiner office practices, including:**
  - Sudden infant or child deaths in which State of New Jersey Autopsy Protocol for Sudden Unexpected Death in Infancy and Childhood was not followed (10 different instances).
  - Premature certification of cause and manner of death prior to completion of investigation, toxicology, or other laboratory results being available (three instances).
  - An unexplained death with no autopsy completed because of parental objection, and with no x-rays completed because the radiology department was “busy.”
  - Post mortem testing of a teen suicide death by hanging which did not include the extensive toxicology and drug screen.
  - No requests made for psychiatric treatment records during the investigation of a hanging death of a juvenile who was reportedly prescribed three different psychotropic medications, yet had negative toxicology results.
  - In the case of a child who died as a result of blunt force trauma with an undetermined manner, the autopsy report documented multiple bite marks; however, there was no documented evidence that dental forensics or isolation of salivary trace evidence was used to evaluate this case. Additionally, the eyes were removed for ophthalmic pathology but the results, crucial in determining a manner of death, were not referenced in the final autopsy report.
  - In a case in which an autopsy was prohibited by court order, there was no blood work, cultures, toxicology, MRI or x-ray imaging studies done; it was unclear by the autopsy report whether these ancillary tests which may have helped determine a cause and manner of death were also prohibited by court order.
  - A death by suicide in which the manner of death was certified as undetermined, in which a full autopsy and toxicology were not completed.
  - In the death of a five month old infant in which the autopsy found old rib fractures, the father had history of a previous infant death, and there was a surviving child in the home, yet no report was made to child protection services to assess the siblings safety.

▶ **Five letters regarding cases with inadequate scene investigation.**

▶ **Five letters of recommendations by the Board to the Acting State Medical Examiner, including:**

- Discontinued use of “babygrams,” and adoption of American Association of Radiologists standards of using skeletal surveys in the autopsy and death investigation of children.
- Mandatory death scene investigation protocol for SIDS, unexplained, or undetermined deaths of children under three years old.
- Use of a standard reporting form (similar to the Pediatric RIME Supplemental Checklist) when local police are the first responders and death scene investigators in cases of sudden unexpected child death.
- Development of an autopsy protocol which standardizes a histological eye exam in cases of shaken baby syndrome, head injuries, real or potential suspicion of child abuse, cerebral edema, or any other unexplained deaths of children under the age of three.

▶ **Four additional concerns expressed by the Board:**

- Medical Examiner’s covering a caseload double the maximum recommended standard (two letters-March 2008 and May 2009).
- Substandard autopsy performed by a forensic pathologist and a reoccurring lack of uniform practices among County Medical Examiners.
- Contradicting autopsy information regarding fatal entrance and exit wounds in a case of a child who was fatally wounded by a firearm.

▶ **One letter requesting further information.**

It was noted that only nine of the letters the Board submitted to Medical Examiners received responses, including a case in which the cause and manner of death were amended after further investigation was requested by the Board.

The Board concerns and recommendations noted illustrates that the current medicolegal death investigation system in New Jersey lacks clear and uniform structure and oversight, often resulting in substandard practices. The cases reviewed by the Board demonstrated a need for universal standards of practice and accountability, and a more efficient acquisition and allocation of personnel and resources in the medical examiner offices.

In light of these observations made by clinical reviews of New Jersey child fatality cases, the Board recommends passage of Senate Bill 798 as proposed by Senator Joseph F. Vitale. This bill would help create a uniform medical examiner system by ensuring oversight authority by a State Medical Examiner regarding the practices of county and regional medical examiner offices during forensic investigations. Senate Bill 798 further would enact that the Attorney General would establish regional medical examiner offices in the northern, southern, and central portions of the state, with each county office falling under the jurisdiction of a regional office, further supporting optimum practices and uniform standards for medical examiner offices and death investigations.



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